THE POWER THAT MADE THE BODY, HEALS THE BODY

CAPPIELLO CHIROPRACTIC
562 Saratoga Rd Scotia, NY 12302

CONFIDENTIAL PATIENT HISTORY

This information is confidential. If we do not sincerely believe your problem will respond favorably, we will not be able to accept your case. We will refer you to disciplines we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately, and completely. *Thank YOII.*

Today's Date __ I _____ I __ Firstc-- _____ ----CLast. _____DMale D Female

What you prefer to be called SSN# Birth *Date* __ *I* __ *I* _____

Home Phone (L __ .ɹ _____Cell Phone (L _ .../) _____ _

Emailaddress. _____ _____ _____ _____ _____ _

Street'-- _____City _____ _____ _____ State _____ .Zip Code _____ _

Occupation _____ Employer Office Phone (~ _--'

Address _____ _____ _____ _____ _

Marital Status: S M W D Name ofWifelHusband. _____ _____Spouse Employer _____

In Event of Emergency Nearest Relative _____R.elationship _____Phone ~ _____ _

He~daboutourofficethrough'-- _____ _____ _____

Insurance Information

Workers' Compensation? : *[Jy es UNo (If "Yes" Put W/C or MYA Carrier Information Below) Date of Accident:* __ *1* __ *1* _____ _

Treatment Authorized By: *Claim #*: _____ _

Medicare? : DYes DNo Medicare #: _____ Effective *Date* __ *I* __ *I* _____ _

Primary Insurance Company: _____ _____ _____ _

Address _____ _____ Ins Co Phone ('- ~)

Insured's Narne _____Re\ationship _____ Insured's Date *ofBirth* __ */* __ */* _____ _

Phone# ~ _____ Insured's SS# Insured's Employer _____ _

Group # (plan, Local, or Policy #) _____ _____ _

Reason For Visit

The reason for this visit is a result of:

How did it occur: D Sports D Work D Auto D Trauma D Chronic D Other (please specify) _____ _

When did it occur:

Rate your pain on a scale with 1 being little to no pain, and 10 being unbearable pain: 1 2 3 4 5 6 7 8 9 10

How often do you have this pain? Is there pain when you go from sitting to standing? DYes DNo

Does the pain spread? DYes DNo Is there pain when you cough or sneeze? DYes DNo Do you have headaches? DYes DNo

If you answered "yes" to any of the previous questions, please explain: _____

Is the condition getting worse:	DYes	D No	D Constant	D Comes & Goes
Is this condition interfering with your:	D Work	D Sleep	D or Daily Routine	

If so, please explain: _____

Have you had this condition in the past? DYes DNo If yes, please explain: _____

Have you ever been treated by a medical physician or chiropractor for this condition?

1. Name _____ When consulted _____ DYes DNo Diagnosis _____

Treatment _____

How long did you see the Doctor? _____ How frequently? _____

Results _____

2. Name _____ When consulted _____ Diagnosis _____

Treatment _____

How long did you see the Doctor? _____ How frequently? _____

Results _____

3. Present Family Doctor or PCP _____ _____ _____

Date of last physical examination _____ _____ By what Doctor _____

4. Have you ever seen a Chiropractor before? DYes DNo

If yes, when for what purpose _____

by whom _____ Iength of care _____ -------Phone #: (L__ _____

Health History

Family Health Information:

Many health problems are the result of hereditary disorders, thus information about your family members will give us a better picture of your total health picture.

NAME	Relation	Past and Present Healtb Problems

1. What type of surgeries have you had: TypelWbenIDoctorlRemarks _____

2. Former serious accidents and falls: 0 Auto 0 Work 0 Home 0 Leisure 0 Sports 0 Otber _____

WbatlWben/Symptoms/TreatmentlResults _____

3.List broken Bones: WbatlWbenlRemarks _____

4.List medications that you take: WbatlFrequencylDoctor'slRemarks _____

5. Work Habits:

Seated/Standing- OWork Bench ODesk OCounter OOther _____

Job involves- OBending OStooping OTwisting OTurning OCarrying OWalking OStanding

OLifting (how much weight) OOther _____

Chair- OExecutive OSteno OBench OStool OFolding OOther _____

Shoes- DHigh heels DBoots DSneakers DDress shoes DOther _____ _

Do you wear orthotics, heel lifts, or sole lifts in your shoes? D Yes D No

Leisure/Sedentary activities DStanding DSeated DLying DTV DReading DCard Games DSewing DOther please describe:

6. HABITS

	Heavy	Moderate	Light	None
Alcohol	D	D	D	D
Coffee	D	D	D	D
Tobacco	D	D	D	D
Drugs	D	D	D	D
Exercise	D	D	D	D
Sleep amount (time)	9-12 hrs	6-9 hrs	3-6 hrs	0-3 hrs
Appetite	D	D	D	D

7. DO YOU

Describe Briefly if applicable

Now take vitamins or minerals? DYes DNo

Have an allergy to any drug? DYes DNa

8. DATE OF LAST

	Less than 6 months	6-18 months	Over 18 months	Never
Spinal Examination	D	D	D	D
Physical Examination	D	D	D	D
Chest X-ray	D	D	D	D
Spinal X-ray	D	D	D	D
Urine Test	D	D	D	D

For Women: Do you take birth control? DYes DNo If"Yes" what type? _____ _

Are you Pregnant? DYes DNo

If "Yes" How far along are you?-.--....: _____

Date oflast menstrual period _____ _

Additional Comments:

PLEASE PUT A CHECK MARK BY ANY CONDITION WHICH YOU HAVE OR HAVE HAD.

General

___ Alcoholism
___ Appendicitis
___ Cancer
__ Chills
Chorea
___ Chronic Fatigue
___ Cold Sores
___ Diabetes
___ Diphtheria
___ Eczema
___ Emphysema
__ Epilepsy
___ Fever Blisters
Fever
___ Goiter
Gout
__ HlV/AIDS
___ Influenza
___ Malaria
Measles
___ Multiple Sclerosis
___ Mumps
___ Pneumonia
Polio
___ Rheumatic Fever
Scarlet Fever
Stroke
___ Sweats
___ Thyroid Disorder
___ Tuberculosis
___ Typhoid Fever
___ Unexplained Weight loss
___ Venereal Disease
___ Weight Trouble
___ Whooping Cough

Respiratory

Acne
___ Allergies
___ Asthma
___ Boils
___ Bruise easily
___ Chest colds
___ Chest pain
___ Chronic cough
___ Coughing phlegm/blood

Musculo-skeletal

Arthritis
Bursitis
___ Buttock pain
___ Chest Pain
___ Facial/Jaw pain
___ Facial spasm
Foot|Toe Pain
Hernia
___ Hip Pain
___ Leg Cramps
___ Leg pain upper/lower
___ Low back pain

Cardiovascular

___ Disorder Heart Attack
___ Hardening of arteries
Heart Disease
___ High Blood Pressure
___ Low Blood Pressure
Pain Over Heart
Poor Circulation
___ Rapid Beating Heart
___ Slow Beating Heart
___ Stroke
___ Swelling of ankles

Nervous System

___ Anxiety
Confusion
Convulsions
___ Depression
Dizziness
___ Fainting
___ Forgetfulness
___ Hiccups
___ Hot/Cold spots
Insomnia
___ Irritability
Nervousness
___ Numbness|Tingling
___ Paralysis
___ Personality change
Tension
Tremors

___ Difficulty breathing
___ Dryness
___ Hives/Allergies
__ Itching
___ Pleurisy
___ Shingles
Skin eruptions (rash)
-Wheezing

shoulder/arm

Sciatica
Scoliosis

Gastrointestinal

__ Belching/Gas
___ Black Stool
___ Bloody Stool
___ Chronic Diarrhea
___ Colitis
___ Constipation
___ Diarrhea
___ Difficulty Chewing
___ Difficult Digestion
___ Difficulty Swallowing
___ Distention of abdomen
___ Diverticulitis
___ Excessive Hunger
Excessive Thirst
___ Food Allergy
___ Gall Bladder Trouble
___ Gastritis/Heartburn
___ Hemorrhoids
___ Jaundice
Liver Trouble
___ Nausea
Pain over Stomach
___ Poor Appetite
___ Ulcers/Stomach Disorders
___ Vomiting
___ Vomiting Blood

Genital-Urinary

___ Bed wetting
Bladder Trouble
___ Prostatitis
___ Urine Disorder-excessive
___ Discolored|blood/pus in urine
___ Impotency
___ Urine Disorder- frequent
___ Urine Disorder-painful
___ Urine Disorder-scanty
___ Kidney infection/stones

Females

___ Breast Lumps/congestion
___ Hot Flashes
___ Irregular/cramps
___ Irregular cycle
___ Menopause Symptoms
___ Periods-painful/excessive
___ Previous miscarriage
___ Vaginal discharge

Pain beneath|below breast bone __
Pain between shoulder blades ___
Pain around collar bone _____
Recurring headaches _____
---Restricted movement hand
Restricted movement head/neck
Sore/weak muscles
___ Restricted movement leg/foot _____
Restricted movement
Swollen/painful/stiff joints
---Rheumatism
___ Rib cage pain _____

FINANCIAL RESPONSIBILITY STATEMENT

I understand and agree that insurance policies are an arrangement between an insurance carrier and myself Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctors office will be credited to my account upon receipt. *However, 1 clearly understand and agree that all services rendered me are charged directly to me and that 1 am personally responsible for payment.* I also understand that if I suspend or terminate my care and treatment, against the Doctor's recommendation, *my account balance will be immediately due and payable. Medicare patients are responsible for their co-insurance, deductible and any items deemed Medically Unnecessary by Medicare.* If you have insurance that covers your co-insurance and deductible we will file on your behalf. Any patient 18 years or older will be financially responsible for all charges incurred. For any patient under the age of 18, the parent who accompanies the minor for their first visit will be financially responsible for all charges incurred. *A* $25 *Returned Check Fee will be assessed to your account for every check returned to CCFF as non payable.* With the exception of emergency situations, you will be held financially responsible for any scheduled appointment not canceled *at least* 24 *hours prior to the appointment. In the event of default payment, the undersigned agrees to pay all costs of collection of delinquent amounts, including Court costs, and reasonable attorney foes. A* 1 }:2 % *late foe will be added to any account over 30 days old without activity.*

Patient's signature _____Date____/____/____ SSN# _____- ___- _____

Other Responsible Party _____Date___/____/____ SSN# _____- ___- _____

RECORDS RELEASE: I, _____do hereby authorize Chiropractic Center for Families to release my Medical records or copies of such necessary to process this claim.

Signature Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health
  care operations

Patient's signature Date_____/_____/_____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

*The nature o(chiropractic treatment:*The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement oft the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used. *Possible Risks:* As with any health care procedures, complications are possible following a chiropractic manipulation. Complications could include bone fractures, muscle strain, ligament sprain, joint dislocation, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days oftreatment. The ancillary procedures could produce skin irritations, burns, or minor complications. *Probability o(risks occurring:*The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications seen from taking a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare". *Other treatment options to consider:*Over-the-counter-analgesics; the risks of these medications include irritation to the stomach, liver and kidneys, and other side effects in a significant number of cases. Medical care; typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases. Hospitalization; in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases. Surgery; in conjunction with medical care adds risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases. *Risks o(remaining untreated.·Delay*of treatment allows formation of adhesion's, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult. *Unusual risks:* I have had the following unusual risk of my case explained to me. I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Legal Guardian *1* Patient's Signature _____Date_____

CONSENT TO TREATMENT OF A MINOR CIDLD: I hereby authorize Dr. Nancy and whomever she may designate as assistants to administer chiropractic care as deemed necessary to my (relationship) _____ (Name of child) _____
Dated at_____ (city) _____ (state) _____ this day of _____
Signed: _____ (parent or guardian) Witnessed: _____