Date:_____

PERSONAL HISTORY

Name: _____ DOB: _____ Age: _____ Sex: _____

Address:_____ DL#/State: _____

City/State/Zip:_____

Home Phone:_____ Cell Phone:_____

Employer(s): _____ Work Phone:_____

Type of Work: _____

Status: ☐Single ☐Domestic Partnership ☐Married ☐Widowed ☐Separated ☐Divorced

Spouse:_____ Employer(s):_____

Type of Work: _____

Work Phone:_____ Cell Phone:_____

Name(s) & Age(s) of Children:_____

Is Spouse the Emergency Contact? ☐ Yes ☐ No

Alternate Emergency Contact:_____Relationship: _____

Home Phone:_____Cell Phone:_____

Responsible Parties for Bill: ☒Yourself ☐Spouse ☐Worker's Comp ☐ Medicare ☐Medicaid ☐ Auto Insurance[+]

☐Personal Health Insurance[^] ☐Other: _____

[^]*Health Insurance card must be presented.* [+] *If Auto Insurance, please provide claim/policy information.*

CURRENT HEALTH CONDITION

Unwanted Health Condition(s): _____

Other Doctors Seen for this Condition: ☐ Yes ☐ No Who?_____

Type of Treatment: _____ Results: _____

Condition Onset: _____ Has This Condition Occurred Before? ☐ Yes ☐ No

Is Condition: ☐ Job Related ☐Auto Accident ☐ Home Injury ☐ Fall ☐Other: _____

Date of Accident:_____Time of Accident:_____

Has Report Been Made to Employer: ☐ Yes ☐ No

Medications Currently Taking: ☐ Nerve Pills ☐Pain Killers/Muscle Relaxers ☐ Blood Pressure Medication

☐ Insulin ☐Other:_____

Do You Wear a Shoe Lift? ☐ Yes ☐ No

Any Additional Medical Conditions:_____

_____

PAST HEALTH HISTORY

Any Major Surgery/Operations: ☐ Appendectomy ☐Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery

☐ Broken Bones ☐ Other:_____

Major Accidents/Falls:_____

_____

Date:_____

Hospitalization (Other Than Above):_____

_____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name & Last Visit: _____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

☐ Pneumonia
☐ Rheumatic Fever
☐ Polio
☐ Tuberculosis
☐ Whooping Cough
☐ Anemia
☐ Measles
☐ Mumps
☐ Small Pox
☐ Chicken Pox
☐ Diabetes
☐ Cancer
☐ Heart Disease
☐ Thyroid
☐ Influenza
☐ Pleurisy
☐ Arthritis
☐ Epilepsy
☐ Mental Disorders
☐ Lumbago
☐ Eczema

INTAKE

☐ Coffee
☐ Tea
☐ Alcohol
☐ Cigarettes
☐ White Sugar

Have you been tested HIV positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

☐ Low Back Pain
☐Pain Between Shoulders
☐ Neck Pain
☐ Arm Pain
☐ Joint Pain/Stiffness
☐Walking Problems
☐ Difficulty Chewing/Clicking Jaw
☐ General Stiffness

☐ Gas/Bloating After Meals
☐ Heartburn
☐ Black/Bloody Stool
☐ Colitis

GENITO-URINARY CODE

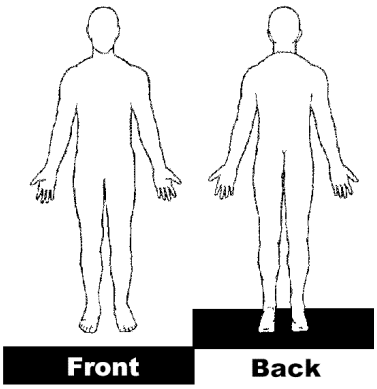
☐ Bladder Trouble
☐ Painful Excessive Urination
☐ Discolored Urine

FEMALES ONLY:

Date of Last Period:

_____

Are you pregnant?
☐ Yes ☐ No ☐ Not Sure



Please outline on the diagram the area of your discomfort.

NERVOUS SYSTEM CODE

☐ Nervous
☐ Numbness
☐ Paralysis
☐ Dizziness
☐ Forgetfulness
☐ Confusion/Depression
☐ Fainting
☐ Convulsions
☐ Cold/Tingling Extremities
☐ Stress

C-V-R CODE

☐ Chest Pain
☐ Short Breath
☐ Blood Pressure Problems
☐ Irregular Heartbeat
☐ Heart Problems
☐ Lung Problems/Congestion
☐ Varicose Veins
☐ Ankle Swelling
☐ Stroke

GENERAL CODE

☐ Fatigue
☐ Allergies
☐ Loss of Sleep
☐ Fever
☐ Headaches

EENT CODE

☐ Vision Problems
☐ Dental Problems
☐ Sore Throat
☐ Ear Aches
☐ Hearing Difficulty
☐ Stuffed Nose

FAMILY HISTORY

The following members have a same/similar problem as I do:

☐ Mother
☐ Father
☐ Sibling
☐ Spouse
☐ Child

GASTRO-INTESTINAL CODE

☐ Poor/Excessive Appetite
☐ Excessive Thirst
☐ Gall Bladder Problems
☐ Abdominal Cramps
☐ Prostate/Sexual Dysfunction
☐ Other Problems

Date:_____

☐Frequent Nausea
☐Vomiting
☐ Diarrhea
☐ Constipation
☐ Hemorrhoids
☐ Liver Problems

MALE/FEMALE CODE
☐ Menstrual Irregularity
☐ Menstrual Cramps
☐ Vaginal Pain/Infection
☐ Breast Pain/Lumps

☐ _____
☐ _____

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relieve of pain or discomfort (*Relief Care*). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (*Corrective Care*). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ Relief Care ☐ Corrective Care ☐ Check Here if you want the Doctor to select the type of care appropriate for your condition(s).

_____ _____
Date Patient Signature

If this is an accident related injury, please fill out the Accident Form. Thank You!

RELIEF CARE:
This is care that is necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

CORRECTIVE CARE:
This differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Corcetti Chiropractic and Rehabilitation Centre will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any other amount authorized to be paid directly to Corcetti Chiropractic and Rehabilitation Centre will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Signature_____ Date _____
Consent to Treat a Minor_____ Date _____
Guardian or Spouse's _____ Date _____
Signature Authorizing Care

Date:_____

FOR OFFICE USE ONLY

ANALYSIS:

DIAGNOSIS:

PATIENT ACCEPTED: ☐ Yes ☐No ☐Referred

_____
Doctor's Signature