Personal and Family Health History

Date_____

Name _____ Social Security _____

Address _____ Occupation _____

City _____State ____ Zip_____ Employer _____

Phone: (H): _____ (W): _____ Marital Status: S M D W

E-mail _____ Spouse's Name _____

Date of Birth _____ Age _____ Spouse's Occupation_____

Referred by: _____

Number of Children and Ages **Previous Chiropractic care?**

Name _____ Age_____ Yes___ No ____ Reason _____

Name _____ Age_____ Yes___ No ____ Reason _____

Name _____ Age_____ Yes___ No ____ Reason _____

You deserve to be healthy. Life is a miracle and so are you. When you were created, you were given all the blueprints, intelligence, tools, and systems to live an active healthy life. Unfortunately, your health can be interfered through accidents and challenges that cause a disruption to your health expression. Through your examination and through your involvement in chiropractic care, we will work to remove these interferences to your natural health expression so that you can live the quality of life you deserve.

Circle all that apply	**Patient**	**Spouse**	**Child #1**	**Child #2**	**Child#3**	**Chiropractor's Comments**
1. Was your birth Traumatic?						
Long Delivery?	Y	Y	Y	Y	Y	_____
Difficult Delivery?	Y	Y	Y	Y	Y	_____
Forceps?	Y	Y	Y	Y	Y	_____
Caesarian?	Y	Y	Y	Y	Y	_____
Breech/cephalic?	Y	Y	Y	Y	Y	_____
2. Growth and Development						
Did you ever once.....						
Learn to care for your spine?	Y	Y	Y	Y	Y	_____
Fall out of bed?	Y	Y	Y	Y	Y	_____
Bang your head?	Y	Y	Y	Y	Y	_____
Breastfeed?	Y	Y	Y	Y	Y	_____
Have childhood sickness?	Y	Y	Y	Y	Y	_____
Have any accidents?	Y	Y	Y	Y	Y	_____
Have surgery?	Y	Y	Y	Y	Y	_____
Fall while learning to walk?	Y	Y	Y	Y	Y	_____
Bullied by your siblings?	Y	Y	Y	Y	Y	_____
Chair pulled out when sitting?	Y	Y	Y	Y	Y	_____
Fall down stairs?	Y	Y	Y	Y	Y	_____
Pulled by your arm?	Y	Y	Y	Y	Y	_____
Experience other trauma?	Y	Y	Y	Y	Y	_____

Circle all that apply	Patient	Spouse	Child # 1	Child # 2	Child # 3	Chiropractor's Comments

3. Current Health Habits

Did/ do you…

Smoke/Use tobacco products?	Y	Y	Y	Y	Y	_____
Drink alcohol/Take Drugs?	Y	Y	Y	Y	Y	_____
Diet (do you eat healthy foods?)	Y	Y	Y	Y	Y	_____
Drink water, how many glasses?	Y	Y	Y	Y	Y	_____
Exercise regularly?	Y	Y	Y	Y	Y	_____
Have teeth problems?	Y	Y	Y	Y	Y	_____
Have eye problems?	Y	Y	Y	Y	Y	_____
Have hearing problems?	Y	Y	Y	Y	Y	_____
Have sleeping problems?	Y	Y	Y	Y	Y	_____
Have occupational stress?	Y	Y	Y	Y	Y	_____
Have physical stress?	Y	Y	Y	Y	Y	_____
Have mental stress?	Y	Y	Y	Y	Y	_____
Have hobbies/sports injuries?	Y	Y	Y	Y	Y	_____

Sleeping posture: side – stomach – back

4. Current Health Condition

Present complaint (be brief) / Reason for your visit today? _____

Pain or Problem started on_____

Pains are: ☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent

Does your pain radiate (travel)? _____

What aggravates your condition/pain? _____

Is condition worse during certain times of the day? _____

Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____

Is this condition getting progressively worse, better, or staying the same? _____

Other Doctors seen for this condition _____

Any home remedies? _____

5. Other Past Health Conditions And/Or Symptoms

☐ Headaches	☐ Muscular In coordination	☐ Prostate Problems	☐ Depression
☐ Neck Pain	☐ Visual Disturbances	☐ Abnormal Weight	☐ Light Bothers Eyes
☐ Upper Back Pain	☐ Dizziness	Gain/Loss	☐ Loss of Memory
☐ Lower Back Pain	☐ Loss of Balance	☐ Loss of Appetite	☐ Ears Ring
☐ Shoulder Pain	☐ Nervousness	☐ Abdominal Pain	☐ Fever
☐ Irritability	☐ Elbow/Upper Arm Pain	☐ Ulcer	☐ Fainting
☐ Wrist pain	☐ High Blood Pressure	☐ Hepatitis	☐ Loss of taste
☐ Hand Pain	☐ Heart Attack	☐ Liver/Gall Bladder	☐ Diarrhea
☐ Chest Pains	☐ Hip/Upper Leg Pain	Disorder	☐ Feet Cold
☐ Stroke	☐ Knee/Lower Leg Pain	☐ Cancer	☐ Hands Cold
☐ Ankle/Foot Pain	☐ Angina	☐ Tumor	☐ Stomach Upset
☐ Jaw Pain	☐ Kidney Stones	☐ Asthma	☐ Constipation
☐ Kidney Disorders	☐ Joint Swelling/Stiffness	☐ Pins & Needles in legs	☐ Loss of Balance
☐ Arthritis	☐ Bladder Infection	☐ Pins & Needles in arms	☐ Buzzing
☐ Painful Urination	☐ Rheumatoid Arthritis	☐ Numbness in fingers	
☐ General Fatigue	☐ Loss of bladder control	☐ Numbness in Toe	

5. Other Past Health Conditions And/ Or Symptoms (cont'd)

What is your height? _____Weight? _____

Have you been under medical and/or drug care?

_____

Do you have a primary care physician? Who?

_____

What medications are you taking?

_____

What side effects have you experienced from the medications and/or surgery?

_____

Do you take vitamins or supplements?

_____

6. Further Family History:

	Heart Disease	Arthritis	Cancer	Diabetes	Other_____
Fathers Side	☐	☐	☐	☐	☐
Mothers Side	☐	☐	☐	☐	☐

How old is, or was, your oldest living relative? _____ years old

As a result of my chiropractic care, I would like to:

Please check all that apply

- ☐ Feel better quickly
- ☐ Have a healthier spine
- ☐ Have a healthier body by keeping my nervous system healthy
- ☐ Live a healthier life style

Insurance Information: (Please present your card to be copied)

What insurance do you have?

Is a referral required?

What is your co-payment?

Assignment of benefits

I irrevocably assign to Dr. Emil A. Tocci, IV all my rights and benefits under any insurance contracts for payment services rendered to me by Dr. Emil A. Tocci, IV. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by Dr. Tocci to be released to him. I irrevocably authorize Dr. Emil A. Tocci, IV to file insurance claims on my behalf for services rendered to me. I irrevocably direct that all such payments go directly to Dr. Tocci. I irrevocably authorize Dr. Emil A. Tocci, IV to act in my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities. This assignment of benefits has been explained to my full satisfaction and I understand its nature and effect. I understand that I am personally responsible for payment for all services rendered in accordance with the regulations of New York.

_____ Signature

_____ Date

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(Print name)
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

Office Use Only
1
4-5
>5

Pain Drawing

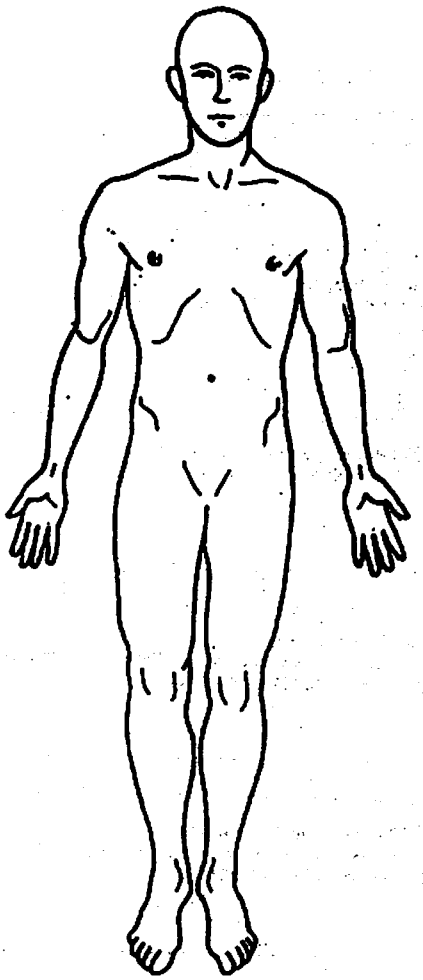
Name:_____ Date:_____

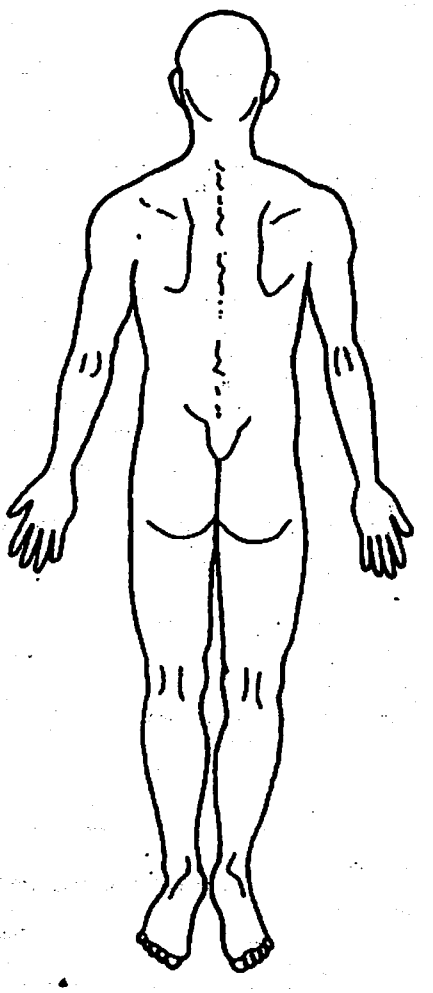
Date of Birth:_____ Examiner:_____

TELL US WHERE YOU HURT.

Please read carefully:
Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it start to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache > > > > > Numbness = = = = = = Pins & Needles o o o o
Burning x x x x Stabbing / / / / / Throbbing ~ ~ ~ ~ ~ ~ ~





Patient's Name: Medicare # (HICN):

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for –**

Items or Services:
Initial Chiropractic Exam any visits exceeding 30
Because:
limitation of coverage

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost:** $ 50.00-initial) in case you have to pay for them yourself or through other insurance. $28.00-visits exceeding 30

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

☐ **Option 1. YES. I want to receive these items or services.**

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

☐ **Option 2. NO. I have decided not to receive these items or services.**

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

Date **Signature of patient or person acting on patient's behalf**

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

OMB Approval No. 0938-0566 Form No. CMS-R-131-G (June 2002)

Emil A. Tocci, D.C.

2421 Long Beach Road
Oceanside, NY 11572
(516) 766-1717

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLWDGEMENT

Patient Name: _____

Date of Birth: _____

I have received this practice's Notice of Private Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Private Practices, and to make changes regarding all protected health information resident at, or controlled by this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____

Relationship to patient (if other that self): _____

Date: _____