TOCCI
FAMILY CHIROPRACTIC
& HOLISTIC LIFESTYLE CENTER

Name: _____ Today's Date: _____
Address: _____ City: _____
State: _____ Zip: _____
Home Telephone: ( ) _____ Work: ( ) _____
Cell: ( ) _____ Email: _____
Male: _____ Female: _____ SSN: _____-_____-_____
Birth Date: _____ Age: _____

Occupation:

_____

Employer name and Address:

_____

_____

Single: _____ Married: _____ Spouse's Name: _____

Have you been to a Chiropractor before? Yes No
If yes, when? _____

Whom may we thank for referring you to our office?

_____

Please check all symptoms you have ever had, even if they do not seem related to your current problems.

Headaches	Pins and Needles in Legs	Menstrual Problems	Neck Stiffness
Pins and needles in arms	Loss of smell	Fainting	Loss of Balance
Dizziness	Ringing in ears	Back Pain	Nervousness
Numbness in fingers	Numbness in toes	Loss of taste	Stomach Upset
Fatigue	Depression	Irritability	Tension
Sleeping Problems	Neck Pain	Cold hands	Cold Feet
Cold Sweats	Constipation	Fever	Hot flashes
Mood swings	Light bother eyes	Heartburn	Seizures

Do you smoke? Yes / No If yes: How many years/ packs per day? _____

List any medications you are taking:

_____

_____

_____

Do you have any medically diagnosed conditions?

_____

_____

Does anyone in your family have any medically-diagnosed conditions, (If so, whom)? :

_____

This office conforms to the current HIPPA guidelines. You may request a copy of our HIPPA policy at the front desk. Please initial to indicate you have been aware of its availability: _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

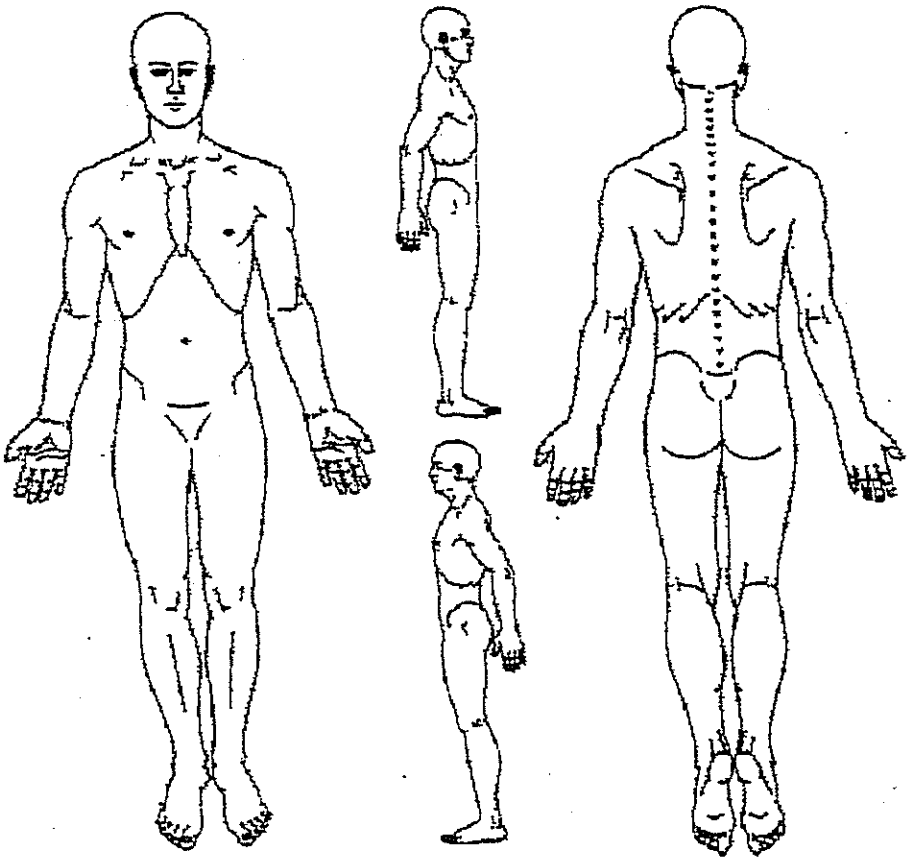
Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
------	OOOOO	^^^^	XXXX	⊗⊗⊗⊗
------	OOOOO	^^^^	XXXX	⊗⊗⊗⊗
------	OOOOO	^^^^	XXXX	⊗⊗⊗⊗



NAME _____ DATE _____

No Pain |——————————————————————| Worst Possible Pain

Please make a slash through this line as to the level of your pain.

_____

Patient Signature

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 used 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)

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NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Patient Name: _____

Date of Birth: _____

I have received this practice's Notice of Privacy 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 than self):

_____ Date: _____