Personal and Family Health History

Date_____

Name _____ Social Security _____

Address _____ Occupation _____

City _____State ____ Zip_____ Employer _____

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

E-mail _____ Spouse's Name _____

Date of Birth _____ Age _____ Spouse's Occupation_____

Referred by: _____ Previous Chiropractic Care: Yes___ No___

On a scale of 1 to 10, how important is your health? _____

What is your primary health and life goal? _____

5 years from now? _____

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 Toes

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	☐	☐	☐	☐	☐

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.

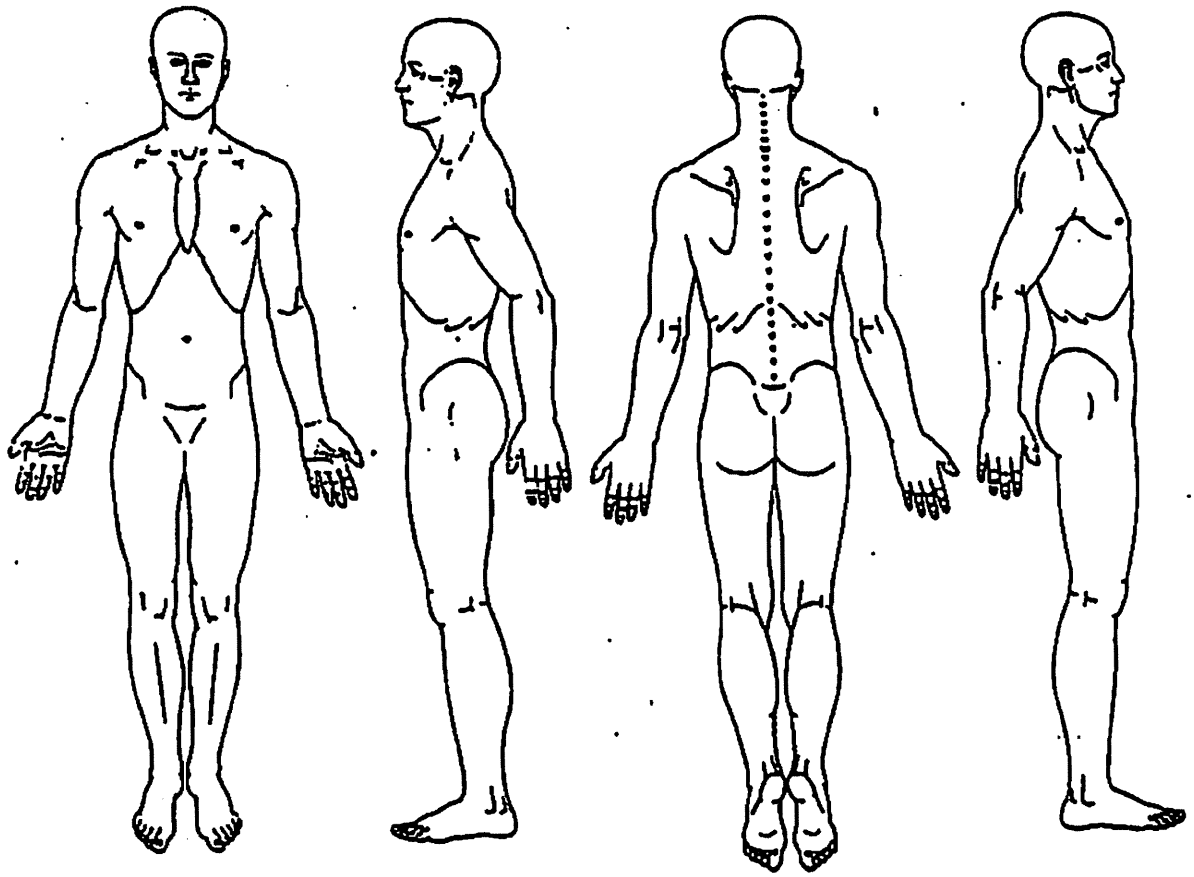
_____ _____
Signature Date

PAIN DRAWING

DATE_____ NAME_____

Please use the following descriptive symbols on the body outlines below to describe the location of your problem. In addition, mark the level of your pain on the pain line at the bottom of the page.

Ache	Burning	Numbness	Pins & Needles	Stabbing	Other
^^^	▭▭▭▭	0000	.....	//////////	XXXX
^^	▭▭▭	00	.....	//////	XXX



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

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

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)

Emil A. Tocci, D.C., CCWP, CCSP, CCN

3089 Lawson Blvd.
Oceanside, N.Y. 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: _____