FAMILY CHIROPRACTIC CARE
PATIENT HEALTH QUESTIONNAIRE

Patient Name______________________________ **Date**____________________

What type of regular exercise do you perform? ☐ None ☐ Light ☐ Moderate ☐ Strenuous

What are your overall health goals? ☐ Weight loss ☐ More Energy ☐ Healthy Aging
☐ Increased Performance ☐ Enhanced Mental Clarity ☐ Decrease Stress ☐ Eliminate Bad Habits
☐ Improve Lifestyle ☐ Other: ____

Past	Present	Condition
☐	☐	Headaches
☐	☐	Neck Pain
☐	☐	Upper Back Pain
☐	☐	Mid Back Pain
☐	☐	Low Back Pain
☐	☐	Shoulder Pain
☐	☐	Elbow Pain
☐	☐	Elbow/upper arm pain
☐	☐	Wrist Pain
☐	☐	Hand Pain
☐	☐	Hip/Upper Leg Pain
☐	☐	Knee/Lower Leg Pain
☐	☐	Ankle/Foot Pain
☐	☐	Jaw Pain
☐	☐	Joint Swelling/Stiffness
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	General Fatigue
☐	☐	Muscular Incoordination
☐	☐	Visual Disturbances
☐	☐	Dizziness

Past	Present	Condition
☐	☐	High Blood Pressure
☐	☐	Heart Attack
☐	☐	Chest Pains
☐	☐	Stroke
☐	☐	Angina
☐	☐	Kidney Stones
☐	☐	Kidney Disorders
☐	☐	Bladder Infection
☐	☐	Painful Urination
☐	☐	Loss of Bladder Control
☐	☐	Prostate Problems
☐	☐	Abnormal Weight Gain/Loss
☐	☐	Loss of Appetite
☐	☐	Abdominal Pain
☐	☐	Ulcer
☐	☐	Hepatitis
☐	☐	Liver/Gall Bladder Disorder
☐	☐	Cancer
☐	☐	Tumor
☐	☐	Asthma
☐	☐	Chronic Sinuitis

Past	Present	Condition
☐	☐	Diabetes
☐	☐	Excessive Thirst
☐	☐	Frequent Urination
☐	☐	Smoking/Tobacco Use
☐	☐	Drug/Alcohol Dependence
☐	☐	Allergies
☐	☐	Depression
☐	☐	Systemic Lupus
☐	☐	Epilepsy
☐	☐	Dermatitis/Eczema/Rash
☐	☐	HIV/AIDS

Females Only

Past	Present	Condition
☐	☐	Birth Control Pills
☐	☐	Hormonal Replacement
☐	☐	Pregnancy

Other Health Problems/Issues

Past	Present	Condition
☐	☐	____________________
☐	☐	____________________
☐	☐	____________________

Indicate if an immediate family member has had any of the following:

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Lupus ☐ _______

List all prescription and over-the-counter medications and nutritional/herbal supplements you are taking:

____

List all the surgical procedures you have had and times you have been hospitalized:

____

Patient Signature____ **Date**______________

Patient Health Questionnaire

Name:____ Date:__________________________

1. When did your symptoms start?_____________ Describe your symptoms and how they began:

____

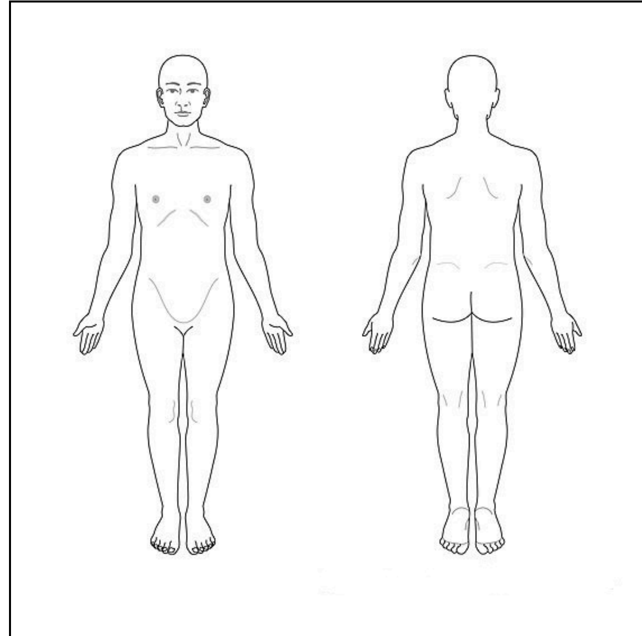
____

2. Symptoms are:

____Occasional ____Frequent

____Constant ____No Pain

Indicate where you have pain or other symptoms on the figures below:



3. What describes the nature of your symptoms:

____Sharp ____Numb

____Burning ____Dull ache

____Shooting ____Tingling

4. How are your symptoms changing?

____Getting Better

____Not Changing

____Getting Worse

5. How do your symptoms affect your ability to perform daily activities?______________________

____

6. What activities make your symptoms worse?____

7. What activities make your symptoms better?____

8. What at-home care have you tried?____

9. How does your condition affect your sleep?____

10. Who have you seen for this particular onset of your condition?

( ) No One ( )Other Chiropractor ( )Medical Doctor ( )Physical Therapist

a. When and what treatment?_____________________________________

b. What tests have you had for your condition and when were they performed?

( ) Xrays Date:________ ( )MRI Date:________ ( )CT Scan Date:________

11. If you have had similar symptoms in the past what did you do to obtain relief?

____

12. What is your occupation?____

13. Do you have a medical doctor you normally see?_____________________________________

14. Have you seen a chiropractor before? ___Yes ___No Who?____________________________

15. Have you had any previous falls, traumas, car accidents or work accidents? Explain:

____

____

Family Chiropractic Care, PC

Financial Policy

Welcome to Family Chiropractic Care P.C. As one of our patients, we feel it is important to advise you of FCC financial policy.

Insurance: Please bring your insurance card with you at each appointment. We cannot obtain your insurance information or bill for your services unless we have your health insurance information. Failure to present your insurance card could result in your visit being rescheduled.

If your insurance has a copayment you are responsible for payment before treatment is rendered. The contract you have with your carrier requires payment at the time of service; therefore payment cannot be waived. You are responsible for any co-insurance, deductibles, or non-covered services not paid by your insurance.

Referrals: If your insurance requires an authorization or referral it is the responsibility of the patient/parent to obtain this information from your primary care physician (PCP) before your appointment. FCC reserves the right to reschedule your appointment without this information.

Payment Methods: FCC will accept payments by the following methods: Cash, check, Visa, MasterCard, Discover and debit cards. FCC will also accept debit/credit for patients/parents with flexible spending or health savings accounts.

Medical Records: FCC will mail or fax a copy of all or a portion of your medical records once a request is received in writing. Records more than 5 pages are subject to a fee of $.75 per page as allowed under the Public Health Law. If you wish for your records to be mailed, there may be an additional fee to cover the mailing cost. Any person picking up records will need to sign a letter of release and show proof of identity.

Financial Charges: A $30.00 charge will be added to your account for any check returned by your bank for any reason. In the event your account is turned over to a Collection agency you may also be liable for attorneys' fees and court cost.

Non-compliance: This is an agreement between FCC as the provider of service and creditor, and patient/debtor named on this form. I have read and understand this policy and all my questions have been answered to my satisfaction.

________________________________ ________________

Patient/Parent/Guardian Date

____

Please Print

PERSONAL FINANCIAL AND INSURANCE INFORMATION

NOTE: A COPY OF YOUR INSURANCE CARD(S) WILL BE MADE FOR YOUR FILE.

NAME:____ DATE:_____________________

MAILING ADDRESS:____
PO BOX / STREET CITY / STATE / ZIP

EMAIL ADDRESS:____

HOME PHONE: ( ) ___________ CELL PHONE: ( )_____________ WORK: ( )__________

SOCIAL SECURITY # ________________EMPLOYED (circle) YES NO PART FULL

DATE OF BIRTH: _____________ AGE: _____ EMPLOYER: ___________________________

EMPLOYER ADDRESS: ____

MARITAL STATUS (circle) S M D W Sep Other IS PATIENT A STUDENT? YES NO

IS PATIENT COVERED BY MEDICARE? YES NO MEDICAID? YES NO

PRIMARY INSURANCE COMPANY (if any): ____

POLICY HOLDER FOR PRIMARY (first) INSURANCE: _________________________________
This person is (circle) Self Spouse Child Other

SECONDARY INSURANCE COMPANY (if any): _____________________________________

POLICY HOLDER FOR SECOND INSURANCE COMPANY: _____________________________

HOW DID YOU HEAR OF OUR OFFICE? ____

Patients or Authorized Individuals Signature
I authorize the release of any medical information necessary to process this claim.

Signed: ____ Date: ______________

I authorize direct payment of medical benefits to **FAMILY CHIROPRACTIC CARE, P.C.** or **MANDY K. VASSALLO, D.C.** Or **SAM VASSALLO, D.C.** as applicable.

Signed: ____ Date: ______________

If your insurance has a copayment you are responsible for payment before treatment is rendered. The contract you have with your carrier requires payment at the time of service; therefore payment cannot be waived. You are responsible for any co-insurance, deductibles, or non-covered services not paid by your insurance.

Signed:____Date:_______________

Medicare Patients Only
Medicare will consider covering Chiropractic Treatments ONLY after your deductible has been met. Examinations are not applied to your deductible amount. Under most instances, Medicare will cover 80% of each office visit up to twelve (12) per year. Any charges for visits in excess of twelve (12) per year, examinations, x-rays or additional therapy ordered are the responsibility of the patient.

Signed: ____ Date: _______________

Chiropractic Informed Consent

For your information the following is furnished to all patients who request and/or accept chiropractic care in this clinic. Again, chiropractic care does not use drugs or surgery, and does not diagnose internal and/or medical conditions. This clinic is staffed with graduate chiropractors who are licensed and recognized by government agencies regulating all the aforementioned healing arts.

You should understand the benefits of chiropractic health care, but you also need to be aware of come of the limited inherent risks. These occur seldom enough to contraindicate care, but should be considered in your informed decision to receive chiropractic care.

Appropriate tests will be performed to identify if you may be susceptible to these risks, and you will be notified, in that case. If you have any questions about these issues, please do not hesitate to speak with your doctor of chiropractic. If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

I request and consent to the performances of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical mylopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do expect the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the risks are not guaranteed.

I have read (or have had read to me) the above information. I wish to rely on the doctor's judgment during my course of care, based on the facts then known I have also had opportunity to ask questions regarding the above information and possible consequences and risks. By signing below, I now agree to have the chiropractic care procedures recommended and performed. I have no questions, and I acknowledge no guarantee of cure has been made to me concerning results, care and treatment.

Print Name:____

Signature:____________________________________Date:__________

Family Chiropractic Care, P.C.
Drs Mandy & Sam Vassallo
24304 NYS Rte 37
Watertown, NY 13601

<u>Consent of Disclosure</u>

I herby give consent to Family Chiropractic Care, P.C. and all health care providers furnishing care within Family Chiropractic Care, P.C. to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the address at the bottom of this form. This may be delivered in person or by mail, but it will only be effective when we actually receive it. Your cancellation will not be effective to the extent that others or we have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclosure of your protected health information for the purposes of treatment, payment or health operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us.

We reserve the right to amend the terms of our Posted Privacy Policy.

Print Name:____

Signature:_______________________________________Date:__________
If you are signing as a patient's representative:
Print your name:____

Relationship:____

<u>Cancellation</u>

I hereby void the consent given above.

Print Name:____

Signature:_______________________________________Date:__________
If you are signing as a patient's representative:
Print your name:____

Relationship:____

Address for cancellation: Your cancellation will be effective, upon receipt at the following address:

<u>Family Chiropractic Care, P.C.</u>
<u>24304 NYS Rt. 37</u>
<u>Watertown NY 13601</u>