SACCO Chiropractic

All information you supply is confidential.
We comply with all federal privacy standards.
Please print clearly.

1730 E. Broad Street Ste 1
Hazleton, Pa 18201
570-497-4150

Please Fill Out Form Completely

(Please Print) Todays Date: ________________

Patient Name: ____ Birth-date: ______________________

Address: ______________________________________ City: ___________________ State: _______ Zip: __________

Home/Cell Phone: ________________________________ Email: ____

Occupation: ___________________ Employer: ______________________ Primary Care Physician: _____________________

How did you hear about our office??? ____

Have consulted a Chiropractic before? O No O Yes When? ______________ If so, Whom __________________________

List other doctors consulted for these conditions:
(1) ____ Date seen ____

(2) ____ Date seen ____

Is this injury work-related? _______________ Have you reported it to your employer? ____________________________

Is this injury or illness related to an automobile accident? ________________ (if yes, complete below)

Your Auto Ins. Co. ______________________________________ Policy # ________________ Claim # ________________

Please Mark any Complaints or Regions of Pain (Mark all that apply)

O Neck Pain O Mid-Back Pain O Low Back Pain O Sacral/Buttock Pain

O Right Hip O Left Hip O Right Shoulder O Left Shoulder

O Right Knee O Left Knee O Right Elbow O Left Elbow

O Right Ankle-Foot O Left Ankle-Foot O Right Wrist-Hand O Left Wrist-Hand

O Headaches O Sinus Issues O Muscle Cramps O Muscle Fatigue O Numbness

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Are your symptoms: □ **Getting worse** □ **Getting better** □ **Staying the same**

What is your chief complaint? ____

When did it start? ____

What caused it? ____

What makes pain worse? ____

What makes pain better? ____

Does the pain go down arms or legs? If yes describe ____

Do you have numbness in your hands or feet? If yes describe ___________________________________

Doctors Initials _______

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PATIENT HISTORY

Circle the current pain level of your complaint:

1	2	3	4	5	6	7	8	9	10

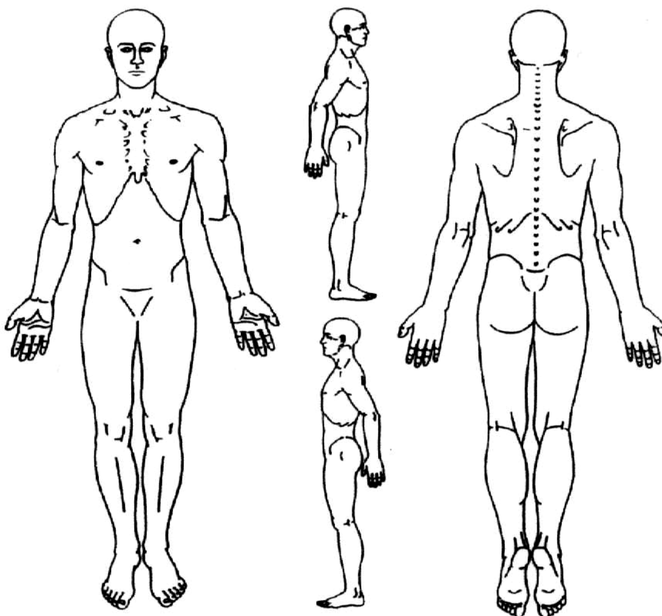
Circle the percentage of day you experience the complaint:

10	20	30	40	50	60	70	80	90	100

When do you feel it most? ☐AM ☐ PM Explain: ____

Please show where on the body below you are experiencing all of your current complaints by circling the area and placing the letter(s) on the left of that specific area.

A: Ache
B: Burning
C: Cramping
D: Dull Pain
F: Stiffness
N: Numbness
R: Throbbing
S: Soreness
T: Tingling
X: Sharp Pain



Do you currently have pain and/or difficultly performing any of the following activities? (Circle Y or N)

Activity		
Walking	Y	N
Standing	Y	N
Running	Y	N
Sleeping	Y	N
Driving	Y	N
Personal Grooming	Y	N
Sitting	Y	N
Kneeling	Y	N
Exercising	Y	N
Bending	Y	N
Lifting Objects	Y	N
Lifting Children	Y	N
Housework	Y	N

Pain Relievers O Daily O Weekly How Much?________________________________
Alcohol Use O Daily O Weekly How Much?__________________________________
Tobacco Use O Daily O Weekly How Much?__________________________________
Coffee Use O Daily O Weekly How Much?__________________________________
Exercising O Daily O Weekly How Much? __________________________________

Are you pregnant? ☐ Yes ☐ No Number of pregnancies? Number of miscarriages?

Have you ever had Surgery (Please include all Surgeries)

*(1)Type*________________________________*When*________________________________

*(2)Type*________________________________*When*________________________________

*(3)Type*________________________________*When*________________________________

Accidents or Injuries in the past (please list all)

Doctors Initials ________

Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild	Moderate	Severe
Sitting	○	○	○	○
Rising out of a chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying Down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a Car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild	Moderate	Severe
Grocery Shopping	○	○	○	○
Household Chores	○	○	○	○
Yardwork	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ________ I instruct the chiropractor to deliver the care that in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence designed to reduce or correct vertebral subluxation. Chiropractic care is a sperate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials ________ I may request a copy of the Privacy Policy and understand it describes how my professional health information is protected and released on my behalf for seeking reimbursement for any involved third parties.

Initials ________ I realize that electric stimulation therapy my be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): __________________

Initials ________ I grant permission to be called to confirm reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials ________ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials ________ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health.

I authorize Sacco Chiropractic to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof.

Signature: ____ Date: ___________________

Doctors Initials

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