WELCOME TO CHIRO & LASER PAIN RELIEF CENTER

Patient Information

Date: _____

First Name:_____

Last Name:_____ Middle Initial:_____

Address_____Apt #_____

City/State_____Zip_____

E-mail_____

Sex ☐ Male ☐ Female

Age_____ Birthdate_____

☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____years

Current Height: _____Current Weight: _____

Number of Children/Ages:

_____

_____

Occupation_____

Patient Employer/School_____

Employer/School Address_____

Spouse's Name_____

How did you hear about our office? _____

Insurance

Insurance Company: _____

Member # : _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Insurance Co. _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent (s) , have insurance coverage with _____ and assign directly to **CHIRO & LASER** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on al insurance submissions.

The above-named office may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please print name of Patient, Parent, Guardian or Personal Representative

_____

Date Relationship to Patient

Contact Information

Home Phone (_____)_____

Cell Phone (_____)_____

Best time & place to reach you_____

IN CASE OF EMERGENCY, CONTACT

Name_____

Relationship_____

Contact Number (_____)_____

Accident Information

Is condition due to an accident? ☐ Yes ☐ No

Date of accident: _____

Type of Accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

Health/History Information

Is today's problem caused by: ☐ Auto Accident ☐ Workman ' s Compensation ☐ Other: _____

How would you rate your overall Health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

What type of exercise do you do? ☐ Stenuous ☐ Moderate ☐ Light ☐ None

What activities do you do at work?

☐ **Sit:** ☐ Most of the day ☐ Half the day ☐ A little of the day

☐ **Stand:** ☐ Most of the day ☐ Half the day ☐ A little of the day

☐ **Driving** ☐ Most of the day ☐ Half the day ☐ A little of the day

☐ **Reads a lot** ☐ **Travels Frequently**

☐ **Computer Work:** ☐ Most of the day ☐ Half the day ☐ A little of the day

☐ **On the Phone:** ☐ Most of the day ☐ Half the day ☐ A little of the day

☐ **Performs Manual Labor:** ☐ Most of the day ☐ Half the day ☐ A little of the day

What activities do you do outside of work? _____

Have you ever been hospitalized? ☐ No ☐ Yes, if yes, why? _____

Have you had significant past trauma ☐ No ☐ Yes

Anything else pertinent to your visit today? _____

Health History

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

	PAST	PRESENT	
Headache	☐	☐ Yes	☐ No
Neck Pain	☐	☐ Yes	☐ No
Upper Back Pain	☐	☐ Yes	☐ No
Mid Back Pain	☐	☐ Yes	☐ No
Low Back Pain	☐	☐ Yes	☐ No
Shoulder Pain	☐	☐ Yes	☐ No
Elbow/Upper Arm Pain	☐	☐ Yes	☐ No
Wrist Pain	☐	☐ Yes	☐ No
Hand Pain	☐	☐ Yes	☐ No
Hip Pain	☐	☐ Yes	☐ No
Upper Leg Pain	☐	☐ Yes	☐ No
Knee Pain	☐	☐ Yes	☐ No
Ankle/Foot Pain	☐	☐ Yes	☐ No
Jaw Pain	☐	☐ Yes	☐ No
Joint Pain/Stiffness	☐	☐ Yes	☐ No
Arthritis	☐	☐ Yes	☐ No
Rheumatoid Arthritis	☐	☐ Yes	☐ No
Cancer	☐	☐ Yes	☐ No
Tumor	☐	☐ Yes	☐ No
Asthma	☐	☐ Yes	☐ No
Chronic Sinusitis	☐	☐ Yes	☐ No
Other: _____			

	PAST	PRESENT	
High Blood Pressure	☐	☐ Yes	☐ No
Heart Attack	☐	☐ Yes	☐ No
Chest Pains	☐	☐ Yes	☐ No
Stroke	☐	☐ Yes	☐ No
Angina	☐	☐ Yes	☐ No
Kidney Stones	☐	☐ Yes	☐ No
Kidney Disorder	☐	☐ Yes	☐ No
Bladder Infection	☐	☐ Yes	☐ No
Painful Urination	☐	☐ Yes	☐ No
Loss of Bladder Control	☐	☐ Yes	☐ No
Prostate Problems	☐	☐ Yes	☐ No
Anormal Weight Gain/ Loss	☐	☐ Yes	☐ No
Loss of Appetite	☐	☐ Yes	☐ No
Abdominal Pain	☐	☐ Yes	☐ No
Ulcer	☐	☐ Yes	☐ No
Heptatis	☐	☐ Yes	☐ No
Liver/Gall Bladder	☐	☐ Yes	☐ No
Disorder	☐	☐ Yes	☐ No
General Fatigue	☐	☐ Yes	☐ No
Muscular Incoordination	☐	☐ Yes	☐ No
Visual Disturbances	☐	☐ Yes	☐ No
Dizziness	☐	☐ Yes	☐ No

	PAST	PRESENT	
Diabetes	☐	☐ Yes	☐ No
Excessive Thirst	☐	☐ Yes	☐ No
Frequent Urination	☐	☐ Yes	☐ No
Smoking/Tobacco	☐	☐ Yes	☐ No
Drug/Alchohol	☐	☐ Yes	☐ No
Dependance	☐	☐ Yes	☐ No
Allergies	☐	☐ Yes	☐ No

If yes, list allergies: _____

_____

Depression	☐	☐ Yes	☐ No
Systemic Lupus	☐	☐ Yes	☐ No
Epilepsy	☐	☐ Yes	☐ No
Dematitis/Eczema/Rash	☐	☐ Yes	☐ No
HIV/AIDS	☐	☐ Yes	☐ No

Do you have any immediate family members with:

☐ ALS ☐ Cancer ☐ Diabetes ☐ Lupus

☐ Heart Problems ☐ Rheumatoid Arthritis

☐ Other: _____

List all prescription medications you are currently taking:

Name	For what?
_____	_____
_____	_____

List all of the over-the-counter medications you are currently taking:

Name	For what?
_____	_____
_____	_____
_____	_____

Are you taking any nutritional supplements? ☐ No ☐ Yes, if yes, please list: _____

List all surgical procedures you have had:

Type/procedure (please describe)	Date/Year (estimate)
_____	_____
_____	_____
_____	_____

Have you been to a Chiropractor before?

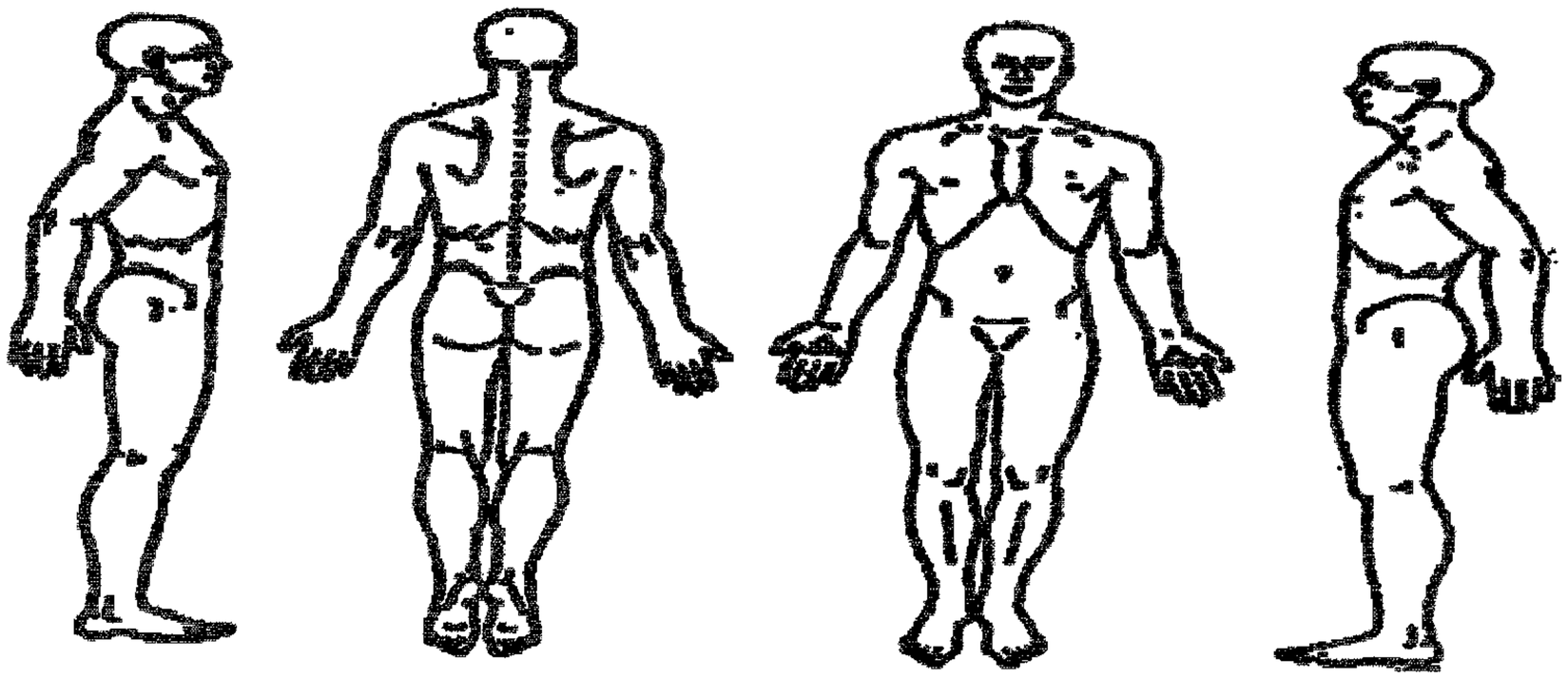
☐ NO ☐ YES, if yes, who? _____ Last visit date, approx:_____

How would you rate your past results? ☐ GREAT ☐ GOOD ☐ FAIR ☐ MIXED ☐ POOR

COMPLAINT #1

Region of Complaint: _____

1. Indicate on the drawings below where you have pain/symptoms:



2. How often do you experience your symptoms?

- ☐ Constantly (76-100% of the time)
- ☐ Frequently (51-75% of the time)
- ☐ Occasionally (26-50% of the time)
- ☐ Intermittently (1-25% of the time)

3. How would you describe the type of pain?

- ☐ Sharp ☐ Numb ☐ Dull ☐ Tingly ☐ Diffuse ☐ Achy ☐ Burning ☐ Shooting ☐ Stiff
- ☐ Sharp with motion ☐ Shooting with motion ☐ Stabbing with motion ☐ Electric like with motion
- ☐ Other: _____

4. How are your symptoms changing with time?

☐ Getting Worse ☐ Staying the Same ☐ Getting Better

5. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

6. How much has the problem interfered with your work?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

7. How much has the problem interfered with your social activities?

☐ Not at all ☐ A little bit ☐ Moderately Quite a bit ☐ Extremely

8. Who else have you seen for your problem?

- ☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician ☐ ER physician ☐ Orthopedist ☐ Massage Therapist
- ☐ Physical Therapist ☐ No one ☐ Other: _____

9. How long have you had this problem? (approximate date) _____

10. How do you think your problem began? _____

11. Do you consider this problem to be severe? ☐ Yes ☐ Yes, at times ☐ No

12. What aggravates your problem? _____

13. What concerns you the most about your problem; what does it prevent you from doing? _____

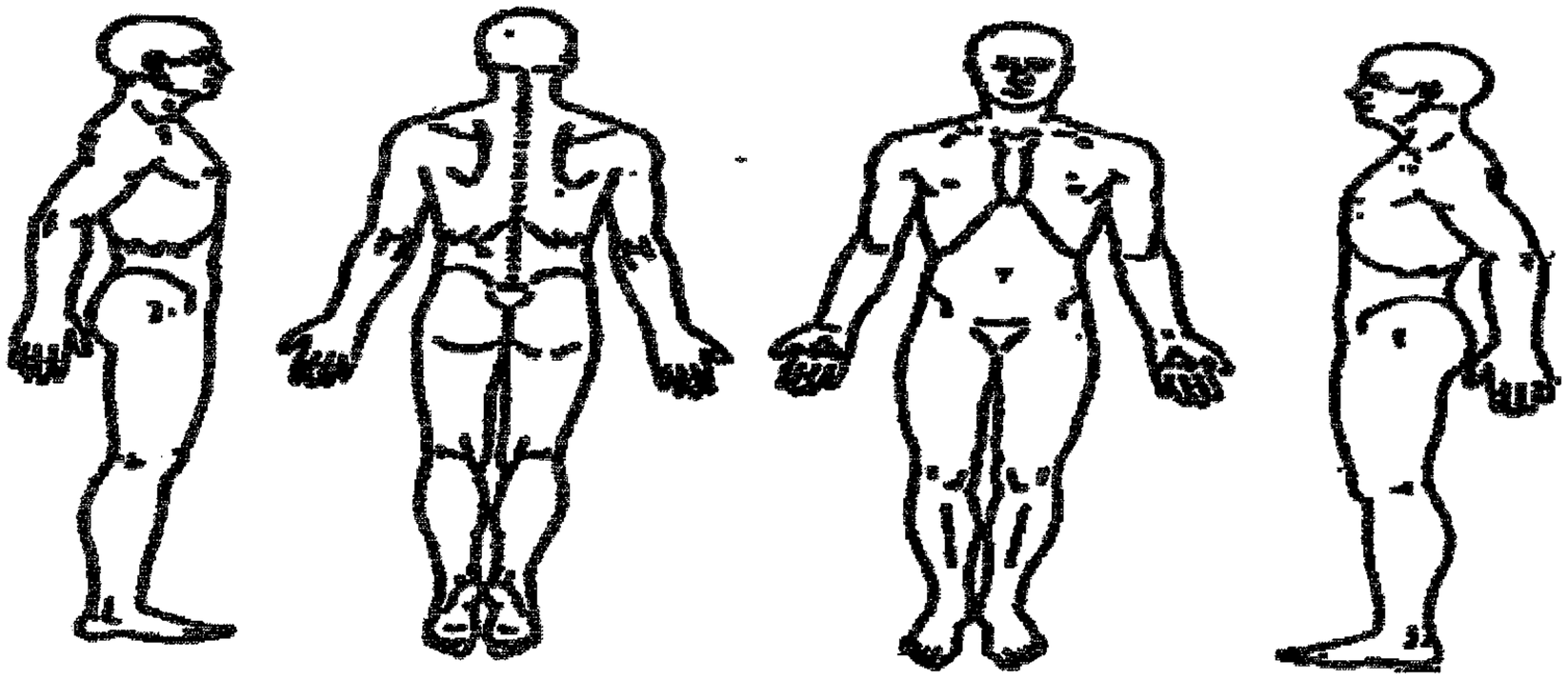
14. What alleviates your problem? _____

COMPLAINT #2

(ONLY FILL OUT IF YOU HAVE ANOTHER COMPLAINT)

Region of Complaint: _____

1. Indicate on the drawings below where you have pain/symptoms:



2. How often do you experience your symptoms?

- ☐ Constantly (76-100% of the time)
- ☐ Frequently (51-75% of the time)
- ☐ Occasionally (26-50% of the time)
- ☐ Intermittently (1-25% of the time)

3. How would you describe the type of pain?

☐ Sharp ☐ Numb ☐ Dull ☐ Tingly ☐ Diffuse ☐ Achy ☐ Burning ☐ Shooting ☐ Stiff
☐ Sharp with motion ☐ Shooting with motion ☐ Stabbing with motion ☐ Electric like with motion
☐ Other:_____

4. How are your symptoms changing with time?

☐ Getting Worse ☐ Staying the Same ☐ Getting Better

5. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

6. How much has the problem interfered with your work?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

7. How much has the problem interfered with your social activities?

☐ Not at all ☐ A little bit ☐ Moderately Quite a bit ☐ Extremely

8. Who else have you seen for your problem?

☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician ☐ ER physician ☐ Orthopedist ☐ Massage Therapist
☐ Physical Therapist ☐ No one ☐ Other:_____

9. How long have you had this problem? (approximate date) _____

10. How do you think your problem began? _____

11. Do you consider this problem to be severe? ☐ Yes ☐ Yes, at times ☐ No

12. What aggravates your problem?_____

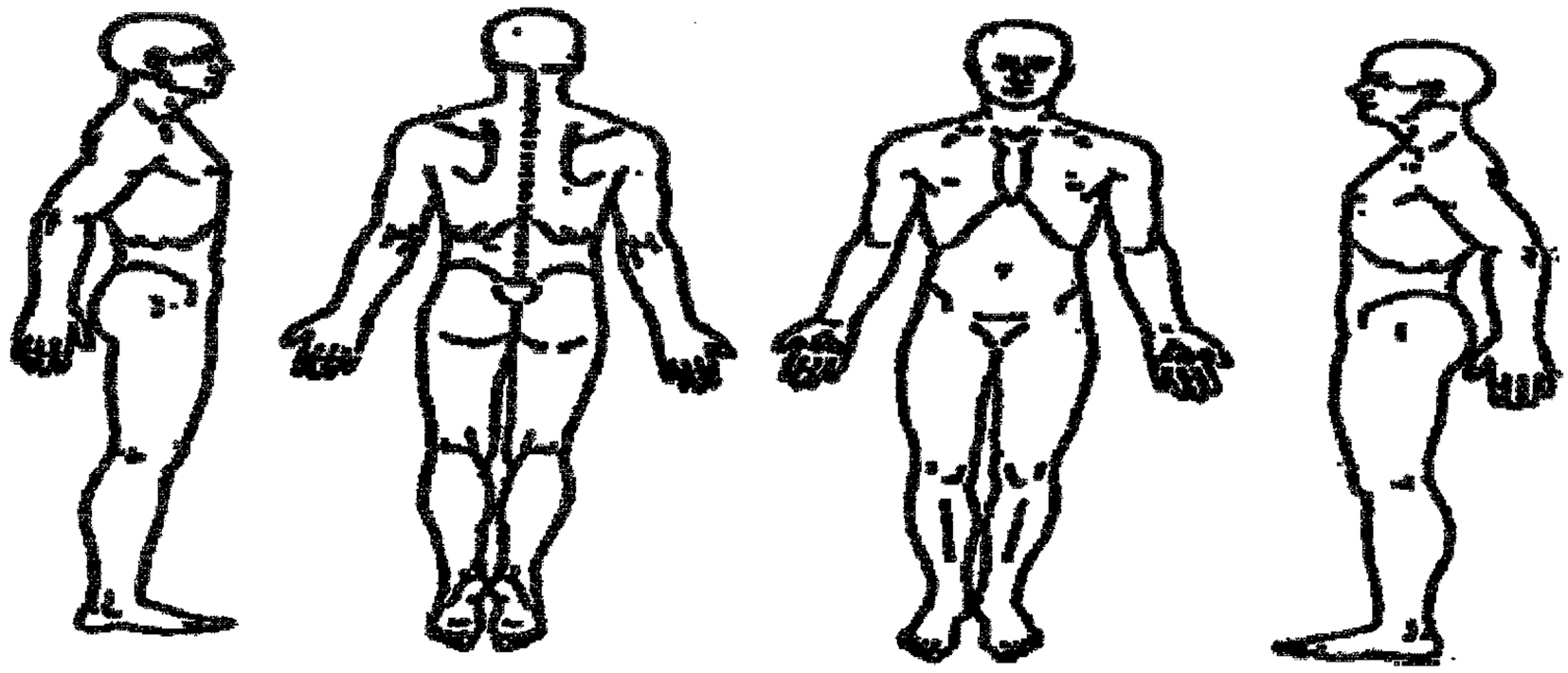
13. What concerns you the most about your problem; what does it prevent you from doing?_____

14. What alleviates your problem?_____

COMPLAINT #3
(ONLY FILL OUT IF YOU HAVE ANOTHER COMPLAINT)

Region of Complaint: _____

1. Indicate on the drawings below where you have pain/symptoms:



2. How often do you experience your symptoms?

- ☐ Constantly (76-100% of the time)
- ☐ Frequently (51-75% of the time)
- ☐ Occasionally (26-50% of the time)
- ☐ Intermittently (1-25% of the time)

3. How would you describe the type of pain?

☐ Sharp ☐ Numb ☐ Dull ☐ Tingly ☐ Diffuse ☐ Achy ☐ Burning ☐ Shooting ☐ Stiff
☐ Sharp with motion ☐ Shooting with motion ☐ Stabbing with motion ☐ Electric like with motion
☐ Other: _____

4. How are your symptoms changing with time?

☐ Getting Worse ☐ Staying the Same ☐ Getting Better

5. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

6. How much has the problem interfered with your work?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

7. How much has the problem interfered with your social activities?

☐ Not at all ☐ A little bit ☐ Moderately Quite a bit ☐ Extremely

8. Who else have you seen for your problem?

☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician ☐ ER physician ☐ Orthopedist ☐ Massage Therapist
☐ Physical Therapist ☐ No one ☐ Other: _____

9. How long have you had this problem? (approximate date) _____

10. How do you think your problem began? _____

11. Do you consider this problem to be severe? ☐ Yes ☐ Yes, at times ☐ No

12. What aggravates your problem? _____

13. What concerns you the most about your problem; what does it prevent you from doing? _____

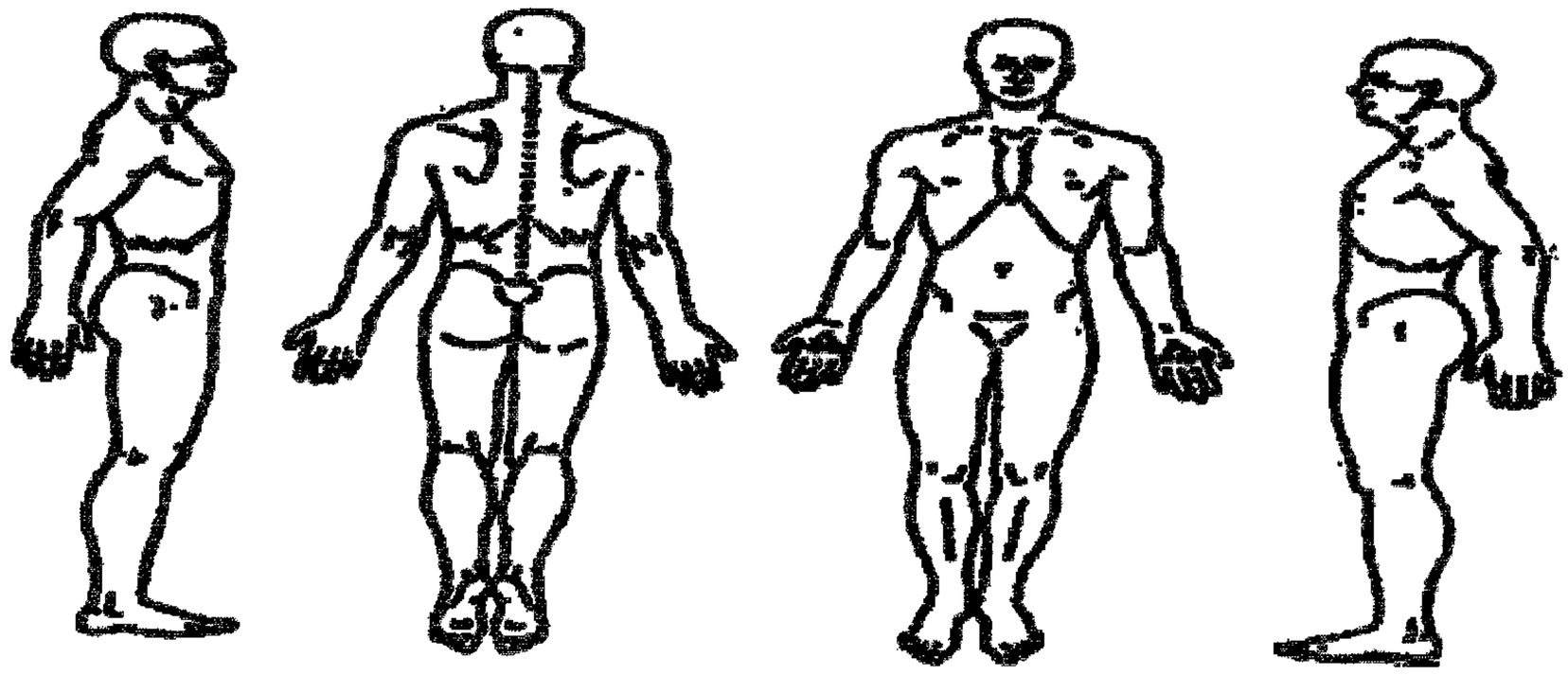
14. What alleviates your problem? _____

COMPLAINT #4

(ONLY FILL OUT IF YOU HAVE ANOTHER COMPLAINT)

Region of Complaint: _____

1. Indicate on the drawings below where you have pain/symptoms:



2. How often do you experience your symptoms?

- ☐ Constantly (76-100% of the time)
- ☐ Frequently (51-75% of the time)
- ☐ Occasionally (26-50% of the time)
- ☐ Intermittently (1-25% of the time)

3. How would you describe the type of pain?

☐ Sharp ☐ Numb ☐ Dull ☐ Tingly ☐ Diffuse ☐ Achy ☐ Burning ☐ Shooting ☐ Stiff
☐ Sharp with motion ☐ Shooting with motion ☐ Stabbing with motion ☐ Electric like with motion
☐ Other:_____

4. How are your symptoms changing with time?

☐ Getting Worse ☐ Staying the Same ☐ Getting Better

5. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

6. How much has the problem interfered with your work?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

7. How much has the problem interfered with your social activities?

☐ Not at all ☐ A little bit ☐ Moderately Quite a bit ☐ Extremely

8. Who else have you seen for your problem?

☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician ☐ ER physician ☐ Orthopedist ☐ Massage Therapis
☐ Physical Therapist ☐ No one ☐ Other:_____

9. How long have you had this problem? (approximate date) _____

10. How do you think your problem began? _____

11. Do you consider this problem to be severe? ☐ Yes ☐ Yes, at times ☐ No

12. What aggravates your problem? _____

13. What concerns you the most about your problem; what does it prevent you from doing? _____

14. What alleviates your problem? _____

INFORMED CONSENT

The nature of the chiropractic adjustment:

The primary treatment used by the Doctors of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. They may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may sense a feel of movement.

Analysis/Examination/Treatment:

As part of the analysis, examination, and treatment, you are consenting to the following procedures:
- Spinal Manipulative Therapy - Range of Motion Testing
- Muscle Strength Testing – Radiographic Studies
- Palpation - Orthopedic Testing - Posture Analysis
- Hot/Cold Therapy – Vital Signs - EMS
- Basic Neurological Testing - Laser Therapy

The material risks inherent in chiropractic adjustments:

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations muscle strain, cervical myelopathy costovertebral strains and separations, and burns. 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. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring:

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availaibilty and nature of other treatment options:

Other treatment options for your condition may include:
- Self Administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain killers.
-Hospitalization
-Surgery

If you choose the above noted "other treatment options" you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated:

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

(Please check the appropriate block and sign below)

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. **Gary Trupo** and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

Patient's Name: _____

Patient's Signature: _____

Doctor's Signature: _____

HIPPA Notice of Privacy

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at **CHIRO & LASER** , we may disclose personal and health related information about you in the following ways:

- Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment, or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of services provided to you.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

Your name, address, telephone number, e-mail address, and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answer machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

- If we provide health care services to you in an emergency
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

You have a right to receive an accounting of any such disclosure made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subjected to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules. We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would

Like the information in a specific form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy, or amend your health-related information should be provided to us in writing. health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any Change in our privacy notice will apply for all of your health information in our files.

This notice is effective as FIRST DATE OF TREATMENT. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Dated: _____

Patient's Name: _____

Patient's Signature: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND COMMUNICATION PREFERENCES AND AUTHORIZATION

Please read and initial:

___ I acknowledge that I was provided a copy of the Notice of Privacy Practices (HIPAA). I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices (HIPAA). I understand that this form will be placed in my patient chart and maintained for six (6) years unless I provide written notice to revoke this authorization.

___ I understand that the staff at **CHIRO & LASER** may on occasion send me notifications or newsletters via mail or e-mail. I authorize this type of communication to the address and or e-mail address I have provided on my initial paper work.

___ I understand that **CHIRO & LASER** utilizes phone calls, text messaging and e- mail messaging for appointment reminders and or missed appointments. I authorize the staff at **CHIRO & LASER** to contact me with these reminders and leave a voicemail message if necessary.

_____

Patient Name Printed

_____

Patient Signature

_____

Parent/ Guardian Name & Relationship Printed (If under 18)

_____

Parent or Guardian Signature (If under 18)

_____

DATE

List below the names and relationship of people to whom you authorize the Practice to release PHI (protected healthinformation).

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____