Sito Chiropractic at Lumina Station New Patient

PERSONAL INFORMATION:

Name: _____ Date: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cellular #: _____ Work #: _____

Which phone # is the best to contact you regarding appointments? (circle one) Home Cell Work

E-mail Address: _____Social Security # _____

Occupation: _____ Employer: _____

Age: _____ Date of Birth: _____Marital Status (circle one) M S W D

Spouse's Name: _____ Spouse's Phone #: _____

Spouse's Occupation: _____ Spouse's Employer: _____

Number of children (if applicable) _____ Please provide kids date(s) of birth: _____

Emergency Contact: Name_____ Phone #: _____

REFERRAL INFORMATION:

How did you find out about our office? _____

Name of your primary Doctor of Medicine/Clinic: _____

Approximate date of last visit to medical doctor:

Did your medical provider refer you to our office? YES NO

Name of your previous Doctor of Chiropractic/Clinic: _____

Approximate date of last visit to chiropractor: _____

PAYMENT/INSURANCE/PRIVACY PRACTICES INFORMATION

*It is usual and customary to pay for services on the date rendered, unless otherwise arranged

Name of Insurance Company (if applicable): _____

I hereby authorize Sito Chiropractic to administer treatment as is necessary and certify that no guarantees or assurances have been made to me as to the results that may be obtained. I give permission to Sito Chiropractic to treat me in an open room where other patients may overhear some of my protected health information, and I acknowledge that I can speak with the doctor in a private room at any time if necessary at my request. _____

Initial Here

I authorize Sito Chiropractic to furnish my insurance company with a full report of my physical examination, diagnosis, treatment, prognosis, etc. in regard to my treatment if requested by them. I I authorize and direct payment to Sito Chiropractic any sums that may be due for chiropractic services rendered to me. I understand that my insurance policy is a contact between myself and my insurance company, and that I am fully responsible to Sito Chiropractic for all bills submitted for services rendered. I have read and agree to be bound by the terms of this assignment of health insurance benefits. _____

Initial Here

Health Information Privacy Notice: As of April 2003, all health care providers are required by law to advise you how their office will use your health information. The entire notice is displayed in our reception area for your review, if you choose to read it in its entirety. Nothing in this notice will change the way we provide care, obtain payment, or run our office. Please read the Health Information Privacy Notice and sign your initials below, stating that you have been made aware of this Federal Health Information policy. _____

Initial Here

I agree to above authorizations: _____

Patient's Signature Date

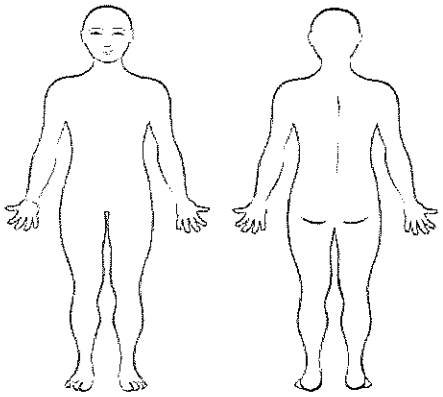
Sito Chiropractic Patient Health Questionnaire

Patient Name_____ Date_____

1. Describe your symptoms, when you first noticed them, and how they began:

Symptom	When first noticed	How symptom began
1)		
2)		
3)		

2. How often do you experience your symptoms?
   - ○ Constantly (76-100% of the day)
   - ○ Frequently (51-75% of the day)
   - ○ Occasionally (26-50% of the day)
   - ○ Intermittently (0-25% of the day)



Indicate where your symptoms occur on the body diagram

3. Describe the timing of your symptoms?
   - ○ Worse in the morning
   - ○ Worse at the end of the day
   - ○ Worse at night
   - ○ The same throughout the day

4. What describes the nature of your symptoms?

Sharp Dull Aching Burning Shooting Throbbing Numb Tingling

5. Do your symptoms radiate into any of the following areas? Please Circle: LEFT | RIGHT | BOTH

Shoulder			Arm			Elbows			Hands			Buttocks			Legs			Knees			Feet		
L	R	B	L	R	B	L	R	B	L	R	B	L	R	B	L	R	B	L	R	B	L	R	B

6. How are your symptoms changing since they began?

Getting Better Not Changing Getting Worse

7. On a scale of 1-10, how would you rate your symptoms at their worst? (1 being "no pain" and 10 being "Unbearable pain")

1(no pain) 2 3 4 5 6 7 8 9 10(unbearable pain)

8. Who else have you seen for your symptoms?

Medical Doctor Other Chiropractor Physical Therapist No One

9. Circle all activities that aggravate your condition/symptoms:

Sitting Standing Walking Bending Stooping Stooping Lifting Sleeping Lying Down
Movement Sneezing Coughing Straining Reaching Twisting Rest Driving Typing
Computer Use Exercise Household Chores Looking Up Looking Down

10. What is your: Height_____ Weight_____ Patient Initials_____

11. For each condition below, place a check mark in the "Past" column if you've had it in the past, and place a check mark in the "Present" column if you currently have it.

	Past	Present			Past	Present
Headaches				High Blood Pressure		
Neck Pain				Heart Attack		
Upper Back Pain				Chest Pains/Angina		
Mid Back Pain				Stroke		
Low Back Pain				Kidney Stones		
Shoulder Pain				Bladder Infection		
Elbow Pain				Loss of Bladder Control		
Wrist Pain				Prostate Problems		
Hand Pain				Abnormal Weight Loss		
Hip Pain				Loss of Appetite		
Knee Pain				Abdominal Pain		
Ankle Pain				Ulcers		
Foot Pain				Indigestion/Reflux		
Jaw Pain				Asthma		
Fatigue				Sinusitis		
Dizziness				Allergies		
Vertigo				Diabetes		
Sinus Pain				Depression		
Arthritis				Cancer/Tumor		

12. Females Only:

	Past	Present
Pregnancy		
Birth Control		
Hormone Replacement		

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

	Mother	Father	Aunt	Uncle	Sister	Brother
Rheumatoid Arthritis						
Heart Problems						
Diabetes						
Cancer						
Lupus						
Other						

14. List all prescriptions and over-the-counter medications you are taking:

_____

15. List all surgical procedures you have had and/or any times you have been hospitalized:

_____

Patient Signature:_____ Date:_____

Sito Chiropractic, P.A.

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Physician of Chiropractic and or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had the opportunity to discuss this with Dr. _____ and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

_____

Print Patient's Name

_____

Patient's Signature

To be completed by the patient's representative if patient is minor or physically or mentally incapacitated:

_____

Print Patient's Name

_____

Print Name of Representative *Signature of Representative*