

Rossi Family Chiropractic Patient History

(Please Print, All information is confidential)

Date: _____

Name: _____

Referred By: _____

Address: _____

Marital Status: M S D W # of Children: _____

City, State, Zip: _____

Spouse's Name _____

Home Phone: _____

Cell Phone: _____

Office Phone: _____

Occupation: _____

E-mail: _____

Employer: _____

DOB: _____ Age: _____

SS# _____

If patient is a minor (under 18yrs old), Please fill out this section. If not, skip:

Parent/ Guardian's Name: _____

Date of Birth: _____ Age: _____

Address: _____

City/State: _____ Zip: _____

Phone # _____ SS# _____

Insurance Name: _____

Policy/ Card # _____

Secondary: _____

Policy/ Card # _____

Please present insurance card(s) to the front desk, so we can copy them.

Permanent Resident/ Seasonal

Chief complaint or reason for today's visit? _____

How long have you had this condition? _____ Date of Onset? _____ Cause? _____

Have you had this condition before? _____ If yes, when? _____

Is the condition related to: Work () Auto () Date of Accident: _____ Have you lost days from work? _____

What doctors have you seen for this condition? _____

What did they do? _____

When was your last visit to a Chiropractor? _____ Chiropractor's Name _____

What are your health goals? _____ Smoker Non Smoker

What surgeries have you had? _____

List drugs you now take (prescription & non-prescription): _____

When was your last auto accident? _____

Have you or anyone in your IMMEDIATE family had any of the following conditions:

- | | | | | | |
|--|---------------------------------------|---|--|---|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Muscular Sclerosis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Spine Problems | <input type="checkbox"/> Arthritis |

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Please mark X for present conditions, O for past conditions

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Back Curvature | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Numb/ Tingle Pain arms, hands, fingers | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Pain w/ Cough/ Sneeze |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Foot Trouble |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Swollen/ Painful Joints | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Numb/ Tingle Pain legs, feet, toes | <input type="checkbox"/> Frequent Colds/ Flu | <input type="checkbox"/> Mood Changes | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Convulsions/ Epilepsy | <input type="checkbox"/> Difficulty bending or with Household duties | <input type="checkbox"/> Lung Problems |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Cancer | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart Problem |
| <input type="checkbox"/> Difficulty standing, Walking, or Sitting | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Jaw Pain, TMJ, R L | <input type="checkbox"/> Menstrual Problem |
| <input type="checkbox"/> Difficulty with daily activities | <input type="checkbox"/> Depression | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Difficulty exercising | <input type="checkbox"/> Irritable | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Impotence/ Sexual Dysfunction | <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Trouble |
| <input type="checkbox"/> Fractured Bones | <input type="checkbox"/> Tremors | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Auto Accidents | <input type="checkbox"/> Allergies | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> Other Accidents/ Falls | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Diarrhea/ Constipation |
| <input type="checkbox"/> Colon Trouble | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Menopausal Problems |
| <input type="checkbox"/> Pregnant (Now) | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Ear Infection | <input type="checkbox"/> AIDS/ HIV |
| <input type="checkbox"/> ADD/ ADHD | <input type="checkbox"/> Hepatitis (A,B,C) | <input type="checkbox"/> PMS | <input type="checkbox"/> Skin Problems |

Please List Your Chief Complaint

1. _____

Location:	Onset:	What Makes It Worse?	Type of pain:	Pain Radiating? Into:	Severity of Pain 1-10 (10 Worst)	Time Out of a Week
Left	Today	Everything	Aching	Left Head	1	10%
Right	This Week	Nothing	Burning	Right Shoulder	2	20%
Both	This Month	Lifting	Deep	Front Arm	3	30%
Front	This Year	Working	Dull	Back Hand	4	40%
Back		Sitting	Numbing	Ribs	5	50%
		Bending	Sharp	Buttocks	6	60%
		Standing	Soreness	Hip	7	70%
		Sneezing	Stabbing	Leg	8	80%
	Coughing	Stiffness	Foot	9	90%	
		Tenderness		10	100%	
		Tingling				

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Please List Your Secondary Complaint

1. _____

Location:	Onset:	What Makes It Worse?	Type of pain:	Pain Radiating? Into:	Severity of Pain 1-10 (10 Worst)	Time Out of a Week
Left	Today	Everything	Aching	Left Head	1	10%
Right	This Week	Nothing	Burning	Right Shoulder	2	20%
Both	This Month	Lifting	Deep	Front Arm	3	30%
Front	This Year	Working	Dull	Back Hand	4	40%
Back		Sitting	Numbing	Ribs	5	50%
		Bending	Sharp	Buttocks	6	60%
		Standing	Soreness	Hip	7	70%
		Sneezing	Stabbing	Leg	8	80%
		Coughing	Stiffness	Foot	9	90%
			Tenderness		10	100%
			Tingling			

THIS DOCUMENT CONSTITUTES INFORMED CONSENT FOR CHIROPRACTIC CARE.

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. It is important for each patient to understand both the objective and the method that will be used to attain it. This will prevent confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our Chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal, physical, mental and social well being, not merely the absence of disease, symptoms or infirmity.

Vertebral Subluxations: A misalignment of one or more of the 24 vertebrae 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 chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will so advise you. If you desire advice, diagnosis or treatment for those findings we will recommend that you seek the services of the 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 interference to the expression of the body's innate wisdom. Our only method is the specific correction of vertebral subluxations.

POLICIES

1. All first visit charges are payable when services are rendered, since it is impossible to determine what insurance covers without a complete evaluation.
2. The fee paid for X-rays is for the analysis of those X-rays only. The film itself is the property of this office. Original X-rays can not be released; however, copies can be made at minimal charge.
3. I have read Rossi Family Chiropractic's Notice of Patient Privacy Practices.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Rossi Family Chiropractic will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Rossi Family Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all the services rendered to me are charged directly to me and that I am personally responsible for payment.

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In case of emergency, notify _____ Phone # _____

I, _____, have read and fully understand the above statements. 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 that basis _____ (Signature) _____ (Date)

PREGNANCY RELEASE: This is to certify that to the best of my knowledge, I am not pregnant. Rossi Family Chiropractic has my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual period: _____ (Signature) _____ (Date)

COMPLETE IF THE PATIENT IS A MINOR CHILD: child's name: _____

I, _____ being the parent or legal guardian of the aforementioned child have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ (Signature) _____ (Date)