CANTALUPO CHIROPRACTIC DATE:___/___/___

Patricia Cantalupo, DC

PATIENT HISTORY FORM: Please answer ALL questions completely & accurately.

FULL NAME_____ **AGE** _____ **DATE OF BIRTH**_____/_____/_____ **SEX**: M F

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Other:_____

Home mailing address(not P.O. Box)_____ City:_____ State :_____ Zip:_____

Cell phone #: _____ **Work phone #:**_____ **Home phone #:**_____

Email : _____ @ _____ **Children** (# & ages, please): #:_____ Ages:_____

Work Status: ☐Full-time ☐ Part-time ☐Not currently employed ☐ Homemaker ☐Retired ☐ On disability/disabled

Occupation: _____ . **Student Status:** ☐ FULL-TIME ☐ PART-TIME ☐ NOT A STUDENT

Family Doctor_____ **Family Doctor phone #:**_____ **Date of last physical**:_____

Who referred you? ☐ A Patient_____ ☐ Doctor_____ ☐ Other:_____ ☐ N/A

Emergency contact info: PERSON_____**Relationship**:_____**PHONE**_____

PATIENT / GUARDIAN EMPLOYER (If patient is a MINOR), _____ **EMPLOYER'S PHONE** _____

I am currently: ☐ INSURED. If so, with:_____ ☐ Not insured at this time

The reason for today's visit:

**If you have no specific symptom or complaint but request a spinal subluxation evaluation today, Check this box.* ☐ *and bypass the rest of this section, proceed to next page.*

For those of you that do have spinal health concerns, complete the rest of this section below in detail. Thank you.

1. **List the Major reason(s)** for your visit today and describe what it **feels like**:(aches ,sharp/dull/tingles/burns/etc.)*
   Problem:_____ **feels like:** _____
   Cause:_____ When it began: _____
   Usual pain level (1=minimal,10=Extreme) #____, Does the pain travel & to where? Y N _____
   How often do you notice it? ☐ All the time ☐ Every day ☐A few times a week / month / year ☐ with certain activity_____
   How long does an episode last? ☐ ____minutes, ☐ _____hours, ☐ _____days, ☐ _____weeks ☐ non-stop
   What activities or factors **make it feel worse**?_____
   What activities or factors **make it feel better**?_____

2. **List any additional reason(s)** for your visit today and describe what it **feels like**:(aches ,sharp/dull/tingles/burns/etc.)*
   Problem:_____ **feels like:** _____
   Cause:_____ When it began: _____
   Usual pain level (1=minimal,10=Extreme) #____, Does the pain travel & to where? Y N _____
   How often do you notice it? ☐ All the time ☐ Every day ☐A few times a week / month / year ☐ with certain activity_____
   How long does an episode last? ☐ ____minutes, ☐ _____hours, ☐ _____days, ☐ _____weeks ☐ non-stop
   What activities or factors **make it feel worse**?_____
   What activities or factors **make it feel better**?_____

3. **List any additional reason(s)** for your visit today and describe what it **feels like**:(aches ,sharp/dull/tingles/burns/etc.)*
   Problem:_____ **feels like:** _____
   Cause:_____ When it began:_____
   Usual pain level (1=minimal,10=Extreme) #____, Does the pain travel & to where? Y N _____
   How often do you notice it? ☐ All the time ☐ Every day ☐A few times a week / month / year ☐ with certain activity_____
   How long does an episode last? ☐ ____minutes, ☐ _____hours, ☐ _____days, ☐ _____weeks ☐ non-stop
   What activities or factors **make it feel worse**?_____
   What activities or factors **make it feel better**?_____

Please note any previous care provided by other providers for this or a similar problem: (* ***IF NONE****, check this box* ☐ *)*

Provider name & type: _____Location:_____ for what problem?_____

Provider name & type: _____Location:_____ for what problem?_____

Provider name & type: _____Location:_____ for what problem?_____

Review of Body systems: record any symptoms you've noticed either now or in the past year. Be specific –*Thanks*

Head and Neck Region

☐ headaches/migraine: location _____ ☐ tension across shoulders
☐ dizziness/lightheaded_____ ☐ ringing in ears _____
☐ difficulty swallowing ☐ difficulty speaking/facial numbness/ loss of balance:_____
☐ arm/hand weakness: _____ ☐ numbness:_____ ☐ tingling:_____
☐ swollen joints: _____ ☐ muscle spasms:_____
☐ rapid unexplained weight loss ☐ anxiety ☐ depression ☐ fatigue ☐ sinus/allergy
Notes by Dr. _____

Mid Back Region:

☐ mid back pain: _____ ☐ rib pain ☐ asthma ☐ recurrent lung infections
☐ difficulty breathing ☐ shortness of breath ☐ chest pressure/pain_____
☐ heart problems:_____ ☐ high blood pressure ☐ diabetes or hypoglycemia
☐ digestive problems:(gallbladder/stomach)_____ ☐ kidney/liver problems_____
Notes by Dr. _____

Low Back Region

☐ pain: low back/hips/knees/legs/ankles/feet _____
☐ leg/foot weakness:_____ ☐ numbness:_____ ☐ tingling:_____
☐ cramping in legs/Restless Legs. ☐ constipation ☐ diarrhea ☐ Irritable Bowel Syndrome
☐ excess gassiness/bloating ☐ frequent urination ☐ difficulty emptying bladder ☐ weak bladder
☐ painful/irregular menstrual cycle ☐ hormonal problems ☐ fertility issues ☐ hemorrhoids
☐ erectile dysfunction ☐ prostate problems
Notes by Dr. _____

MEDICAL HISTORY INFORMATION:

PREVIOUS /CURRENT ILLNESS: CHECK what pertains to you. **If two choices** given, **circle** correct one. (* ***IF NONE*** *apply check this box* ☐ *)*

_____ High Blood Pressure _____ Liver Disease/Hepatitis _____ Cholesterol _____ Eczema or Psoriasis
_____ Heart Disease _____ Seizures _____ Anxiety _____Allergies
_____ Hepatitis (type) _____ Inflammatory Bowel Disease _____ Thyroid _____ Asthma
_____ Stroke _____ Diabetes or Hypoglycemia _____ Depression _____ Mono/TB
_____ Gastric reflux or ulcers _____ Arthritis _____ HIV or AIDS _____ Kidney disease
_____ Cancer: (type): _____ Autoimmune: (type):_____ Other: _____
Notes: _____
_____

FAMILY HISTORY :Please check any that apply, who it applies to, age, and note if they are deceased. (* ***IF NONE****, check this box* ☐ *)*

☐ Migraines/headaches: _____ ☐ Back/neck pain_____
☐ Diabetes_____ ☐ Cancer (include type) _____
☐ Heart disease _____ ☐ Other:_____ ☐ adopted, no history available
notes:_____

Social History: Record your answer using the following key: **O**=*often* **S**=*sometimes* **N**=*never… for each category.*
Exercise:____ Alcohol use: ___ Tobacco: type____ Caffeine: ____ High Stress situations:____
Family pressures:____ Financial pressures: ____ Diet/sugar-free products:____ Street drugs:____

List any **surgical procedures** done, including spinal or joint related. (* ***IF NONE****, check this box* ☐ *)* _____
_____
_____

List any **hospitalizations** w/details. Please do not include surgical procedures listed previously): (* ***IF NONE****, check this box* ☐ *)*
If yes, explain: _____

Patient Name (printed)**:** _____

Current Medications & why you take them. (*Please include "over the counter" & vitamins, etc.).* **(* *IF NONE,*** *check this box* ☐*)*

1._____ for _____ **2**._____for _____ **3**._____for _____

4._____for _____ **5**._____for_____ **6**. _____for _____

7._____for _____ **8**. _____for _____ **9.** _____for _____

Other:_____.

List any Injuries: **(**that are not car/vehicle related):_____

_____ (* ***IF NONE****, check this box* ☐ *)*

Car/vehicle accidents: [year & type of accident (rear ended, head-on, etc.), type of treatment received] (* ***IF NONE****, check this box* ☐ *)*

1. Year: _____, Type:_____ Treatment? By whom? _____
2. Year: _____, Type:_____ Treatment? By whom? _____
3. Year: _____, Type:_____ Treatment? By whom? _____

Other:_____

*****Attention: Female patients: ARE YOU PREGNANT or ACTIVELY TRYING to become pregnant at this time?** ☐ ***YES*** ☐ ***NO***

Consent & Authorizations for Care

In order to receive an evaluation and/or care administered by this practice, you must read the following and sign below:

Privacy – The health information gathered and created about you (or your children that are minors) will be used for treatment, payment and medical operations. Our office maintains strict, privacy guidelines concerning the use of your personal health information. You can receive a copy of our policy upon request. You may ask for restrictions to be placed on release of personal medical information, however our office may not agree to these restrictions. I present myself (and/or my children) for evaluation, care & management of our spinal health & for no other reason. I hereby authorize Dr. Patricia Cantalupo (and/or any of her trained assistants) to examine, take any clinically indicated x-rays and provide chiropractic care to me (and/or my family) as deemed necessary based on our examination findings. Cantalupo Chiropractic has my permission to release to or obtain my records from… my insurance company, attorney, or any of my doctors, if needed.

NOTICE SPECIFICALLY REGARDING CHILDREN

If I ever bring my children to this office for receive care, I am giving written permission, by signing this document, for Dr. Patricia Cantalupo to make healthcare decisions regarding the Chiropractic care of my child/children since I, the parent/legal guardian listed below may not be present at all of his/her scheduled visits. I understand that I or another parent/legal guardian must be present for my child's first appointment. I also understand this signed consent will be valid until the minor child is 18 years of age, or unless I withdraw this permission in writing.

SIGNATURE AUTHORIZATIONS

I, the undersigned, authorize Dr. Patricia Cantalupo to provide Chiropractic care to me and/or my minor dependent(s). I, the undersigned, authorize release of any medical information or other information necessary to process insurance claims for myself or my minor dependent(s). I, the undersigned, request that payment of authorized Medicare and/or other insurance benefits be made, for me or on my behalf, to Cantalupo Chiropractic for any services furnished by Dr. Patricia Cantalupo or staff. I authorize any holder of medical information about me to release to my insurance carrier and/or Medicare and its agents any information needed to determine these benefits payable for related services. I also give Cantalupo Chiropractic permission to obtain my records from my insurance company, attorney(s), or any of my doctors or hospitals/clinics as needed.

FINANCIAL RESPONSIBILITY AND AUTHORIZATION FOR PAYMENT

I understand that I am financially responsible for payment for services rendered by Cantalupo Chiropractic. I authorize Cantalupo Chiropractic to provide Chiropractic care and to release records and/or medical information for the purpose of insurance claims. I assign payment and/or benefits of said claim(s) directly to Cantalupo Chiropractic. In the case of Medicare, I understand that this office does not take assignment and that I will pay this office at time of service and receive reimbursement, if applicable, directly from Medicare. I understand that all charges not paid by my insurance carrier(s) remain my responsibility. I understand that this office does not extend credit and that all services are required to be paid at time of service. I understand the if the patient is a minor, the legal guardian signing below assumes financial responsibility for the cost of services rendered. I also understand that any request for copies of my or my family's patient files will be at the standard legal rate.

REGARDING RECEIPT OF THIS OFFICE'S HIPAA DOCUMENT

I also acknowledge that I have read and understand this office's HIPAA policy document & was offered a copy of it. I realize that I may elect not to keep a copy of it, knowing that it I can elect to download it from the office web site. I attest to the fact that all the information provided on this form is accurate & truthful and that I have read and understand all the stated policies noted in this document.

SIGNATURE:_____ **DATE**: _____

☐ The Doctor and I have adequately discussed the risks involved with treatment that are specific to my condition & other treatment options. I have also provided the above information freely and accurately. I present myself today for no other reason other than evaluation and treatment.

Signed after discussion with doctor:_____ Date: same as above.

(**or** signature of parent/legal guardian if patient is a minor.)