Patient History

PLEASE PRINT CLEARLY AND FILL IN COMPLETELY

NAME DOB AGE TODAY'S DATE

STREET CITY STATE ZIP

HOME # CELL# MALE ( ) FEMALE ( )

EMAIL: SS#

WHOM CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?

HEALTH HISTORY

REASON FOR VISIT/PROBLEM AREA(S) _____

DATE OF ONSET _____ DURATION: DAYS ( ) MONTHS ( ) YEARS ( ) OTHER: _____

OF EPISODES: 0-3 ( ) 4-5 ( ) MORE THAN 5 ( ) HOW DID THE ISSUE BEGIN: _____

TYPE OF PAIN: SHARP ( ) DULL ( ) SHOOTING ( ) THROBBING ( ) TINGLING AND NUMBNESS ( )

RATE THE SEVERITY OF YOUR PAIN ON A SCALE FROM 1 (LEAST PAIN) TO 10 (MOST PAIN): _____

HOW OFTEN DOES THE PAIN OCCUR: CONSTANT ( ) INTERMITTENT ( ) OCCASIONAL ( )

WHAT MAKES IT WORSE: _____

WHAT MAKES IT BETTER: _____

IS THE CONDITION WORSE DURING CERTAIN TIMES OF THE DAY?: _____

THIS CONDITION INTERFERS WITH: WORK ( ) SLEEP ( ) ROUTINE ( ) OTHER ( )

RESTRICTIONS OF DAILY LIVING ON A SCALE FROM 1 (NO LIMITS) TO 10 (TOTAL DISABILITY)_____

IS THE CONDITION GETTING PROGRESSIVELY WORSE? YES ( ) NO ( ) EXPLAIN: _____

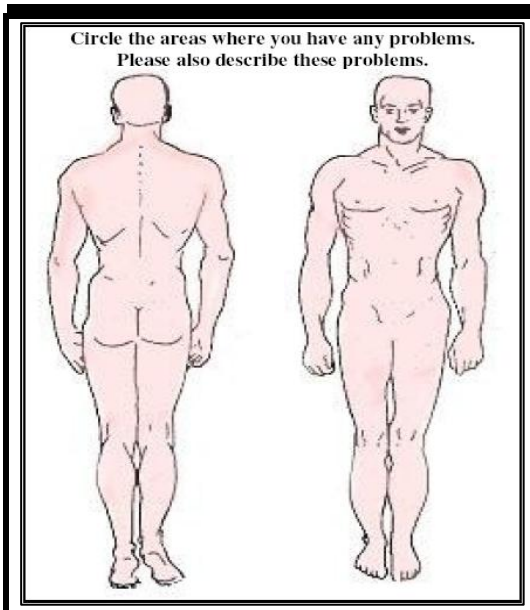
MOVEMENTS THAT ARE PAINFUL: SITTING ( ) STANDING ( ) WALKING ( ) BENDING ( ) LYING DOWN ( )

ARE YOU UNDER THE CARE OF ANY OTHER PHYSICIAN? YES ( ) NO ( ) NAME OF DOCTOR: _____

ARE YOU USING ANY HOME REMEDIES?: _____

LIST ANY CURRENT MEDICATIONS: _____

DO YOU HAVE HIGH STRESS: YES ( ) NO ( ) REASON:



PLEASE FILL IN ANY OTHER HEALTH INFO YOU FEEL WE MIGHT NEED FOR YOUR CARE

INJURIES/SURGERIES DESCRIPTION AND DATES

ACCIDENTS/FALLS

BROKEN BONES

SURGERIES

OTHER

IF YOU HAVE/HAD THE FOLLOWING, OR IF YOU SUFFER FROM THE FOLLOWING PLEASE CHECK

Shortness of Breath	O	Diarrhea	O	Loss of Taste	O
Hay Fever	O	Constipation	O	Loss of Balance	O
Allergies	O	Appendicitis	O	Dizziness	O
Back Pain	O	Hemorrhoids	O	Fainting	O
Asthma	O	Ulcers	O	Face Flush	O
Fatigue	O	Liver Trouble	O	Ringing/Buzzing Ears	O
Depression	O	Neck Pain	O	Seizures	O
Lights Bother Eyes	O	Grating/Grinding Neck	O	Tuberculosis	O
Headaches	O	Hip Pain	O	Polio	O
Cold Sweats	O	Limb Pain	O	Gout	O
Earaches	O	Irregular Menstruation	O	Thyroid Trouble	O
Fever	O	Chest Pain	O	Heart Disease	O
Pneumonia	O	Heart Problems	O	Cancer	O
Chronic Cough	O	Shoulder Pain	O	High Blood Pressure	O
Rheumatic Fever	O	Neck Stiff	O	Low Blood Pressure	O
Posture Issues	O	Slipped Disc	O	Kidney Trouble	O
Pins & Needles in Legs	O	Insomnia	O	Tonsilitis	O
Pins & Needles in Arms	O	Exhaustion	O	Arthritis	O
Cold Hands	O	Nervousness	O	Diabetes	O
Cold Feet	O	Tension	O	Urinary Problems	O
Numbness in Fingers	O	ADD/ADHD	O	Painful Menstruation	O
Numbness in Toes	O	Iritability	O	_____	O
Stomach Upset/Nausea	O	Loss of Smell	O	_____	O

EXERCISE		WORK ACTIVITY		HABITS		
NONE	O	SITTING	O	SMOKING	O	PACKS/DAY
MODERATE	O	STANDING	O	ALCOHOL	O	DRINKS/WEEK
DAILY	O	LIGHT LABOR	O	COFFEE	O	CUPS/DAY
HEAVY	O	HEAVY LABOR	O	OTHER	O	

PERSONAL AND FAMILY HISTORY

OCCUPATION: EMPLOYER:

MARITAL STATUS: SPOUSES NAME:

SPOUSES HEALTH STATUS:

CHILDREN'S NAMES, AGES AND HEALTH STATUS:

CHIROPRACTIC HISTORY

HAVE YOU EVER BEEN TO A CHIROPRACTOR? DOCTOR'S NAME

DATE OF LAST CHIROPRACTIC VISIT: REASON FOR CARE:

DATE OF LAST CHIROPRACTIC XRAY: HOW LONG WERE YOU UNDER CARE:

WELLNESS COMMITMENT

At De Saro Chiropractic we are dedicated toward achieving the goal of total lasting health for our patients. To better help you achieve this; we need to understand your commitment toward being healthy. We do not ask for a financial commitment, but we do ask for your cooperative commitment. Based on a scale of 10% to 100% please circle you personal level of commitment toward obtaining and maintaining health and wellness.

10%------20%------30%------40%------50%------60%------70%------80%------90%------100%

Doctor-Patient Relationship in Chiropractic/Privacy Statement

When a person seeks chiropractic care and when a chiropractor accepts a patient for such care, it's essential that they both are seeking and working towards the same goals. Chiropractic has one goal. It is therefore important that you understand the goal and our method to attain it. In this way there will be NO confusion, misunderstanding, or disappointment.

The purpose of Chiropractic is to restore and maintain the integrity of the spinal cord and its' nerve roots. These vital nerve pathways are housed in and protected by the bones of the spine (called vertebra). Misalignments of the vertebra, which interfere with the functions of these pathways, are called SUBLUXATIONS. Subluxations come from many causes and prevent various organs, glands and tissues from functioning properly.

By means of a Chiropractic ADJUSTMENT, subluxations are corrected (reduced). Thus, the normal nerve function restores itself. The goal of Chiropractic is to adjust vertebral subluxations for the purpose of allowing the proper transmission of nerve supply over nerve pathways to every part of the body at all times.

This allows the body's inborn, innate healing ability to work to maximum efficiency. With a proper nerve supply, health improves. In some, symptoms clear up quickly. In others, the process is slower, and in some, it is only partial or not at all. Regardless of what the disease is called, the Chiropractor does not offer to heal or treat it. The Chiropractor's only goal is to allow the body to heal itself and his only means is the correction of the vertebral subluxation.

Please understand that Chiropractic is NOT a substitute for medical treatments of any kind. Also, NO statement of the chiropractor is intended as a medical diagnosis and should not be confused as such. Chiropractic is not intended to be a treatment of the symptoms of a medical condition or to treat the causes of a medical condition.

Only a chiropractor can determine if your case is a chiropractic case. Medical doctors diagnose disease and chiropractors diagnose vertebral subluxations. Your diagnosis in this clinic will reflect spinal nerve interference, which is caused by vertebral subluxations. Our doctors will work with any other health care provider for your benefit. Inversely, you should expect all other health care providers to work together with your chiropractor for your benefit. This team approach to your health care will benefit you the patient the best.

The patient, in coming to the chiropractor, gives the chiropractor permission and authority to adjust the patient for spinal subluxations. If the patient is aware of any latent pathological defects, illness or deformities, which would not otherwise come to the attention of the chiropractor, it is their responsibility to notify the chiropractor. The chiropractor, of course, will not provide chiropractic adjustments if he is aware of any such conditions. The chiropractor provides a specialized health service in the detection and correction of the vertebral subluxation and its related components. Any risks regarding chiropractic treatment will be explained, in detail, upon request.

De Saro Chiropractic Center

The *Standards for Privacy of Individually Identifiable Health Information* ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services issued the Privacy Rule to implement the requirement of the **Health Insurance Portability and Accountability Act** of 1996 ("HIPAA"). A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being.

You can be assured that our clinic takes your privacy seriously and is in compliance with all HIPPA guidelines. Your health information will not be disclosed without your permission or will your name, address or telephone number be disclosed to any third party. Our privacy policy is available at the front desk upon your request.

Just as in any good relationship, proper communication is an absolute necessity. We want to help you attain your goal of health. If at any time your response is not satisfactory, we will gladly assist you in choosing a referral doctor for another opinion. Your health is our number one priority.

I, _____, have read the above, understand it fully and undertake
(Please Print Name)
Chiropractic care on this basis.

Signature _____

Date _____

Witness _____

CONSENT TO TREAT A MINOR CHILD

I hereby authorize Dr.'s De Saro, and whomever they may designate as their assistants to administer treatment as they so deem necessary to my _____,
_____

Signature:_____

Witness:_____

De Saro Chiropractic Center