Gucciardo Specific Chiropractic and Natural Health Center

NEW PATIENT INFORMATION FORM

Please print clearly:

Name____ **Date**_______________

Address____**Apt.#** ________

City ________________________ State__________ ZIP ____________

Shipping Address (if different)____

Home Phone (_____) _______-__________**Work Phone** (_____) _______-__________

Cell Phone (_______) ________-_____________ Social Security # __________________

E-mail address: ____

REFERRED BY:____

Occupation___________________________________ **Employer** ___________________

Date of Birth: ______________ **Age** ______ **Sex:** M/F **Height** ______ **Weight** _______

Overall health (circle one): Excellent / Good / Fair / Poor / Other: _______

Chief complaint (reason you are here): (use separate sheet if more room needed)

____

____

____

____

Previous treatments for this complaint ____

____

Other complaints or problems: (use separate sheet if needed): _________________________

____

Medications you take: [] Nerve Pills [] Pain Killers [] Muscle Relaxers [] Birth Control
[] Anti Depressants [] Tranquilizers [] Insulin [] Blood Sugar Pills [] High Blood Pressure
[] Aspirin/Tylenol [] Others: ____

Are you currently under the care of a physician or other health care professionals?

(If yes, please give name and date of last visit): _____________________________________

____

Name: ____ **Date** _______________

Nutritional supplements you are taking: ____

____

____

Do you smoke, drink coffee or alcohol? (if yes indicate how much)

Cigarettes(per day) _____Coffee(cups per day)______Alcohol(drinks per week)_______

HISTORY:

Have You ever had any of the following diseases or conditions:

[]Heart Attack/Stroke	**[] Heart Surgery/Pacemaker**	**[] Heart Murmur**
[] Congenital Heart Defect	**[] Mitral Valve Prolapse**	**[] Artificial Valves**
[] Alcohol/Drug Abuse	**[] Venereal Disease**	**[] Hepatitis**
[] HIV+/Aids	**[] Shingles**	**[] Cancer**
[] Frequent neck pain	**[] Emphysema**	**[] Anemia**
[] High/Low Blood Pressure	**[] Psychiatric Problems**	**[] Rheumatoid Fever**
[] Severe/Freq. Headaches	**[] Kidney Problems**	**[] Ulcers/Colitis**
[] Fainting/Seizure/Epilepsy	**[] Sinus Problems**	**[] Asthma**
[] Diabetes/Tuberculosis	**[] Difficulty Breathing**	**[] Chemotherapy**
[] Lower Back Problems	**[] Artificial Bones/Joints**	**[] Arthritis**

Have you Ever: [] Knocked Unconscious [] Treated for a spine disorder [] Fractured bone []

List any surgery or operations with approx. date: __________________________________

____

____

Past Accidents or injuries:____

____

MajorFallsChildhood:____

____

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other____

Name: ____ **Date** ______________

Marital Status: S M D W DP **Name of Spouse** _______________

Describe health of spouse: _______________ Number of children if any _____

List any physical conditions or concerns for each:

Name of Child/Spouse	Age	Sex	Condition
____________________	___	M/F	__________________________
____________________	___	M/F	__________________________
____________________	___	M/F	__________________________
____________________	___	M/F	__________________________
____________________	___	M/F	__________________________

Are You Vegetarian? Y / N If so, to what degree? ______________________________

Do you have any religious/or other dietary restrictions and if so what are they?________

____

Any household pets or other animals you or family members are in close contact with:

____

What can we do to make you happier? ___________________________

____

Name of Emergency Contact: _________________________ **Relation:** _______
Number of Emergency Contact: _________________________

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor. I authorize my insurance company to pay to the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. ***Payment is due in full at time of treatment unless prior arrangements have been approved.***

SIGNED:_____________________________________ **DATE:** _____________

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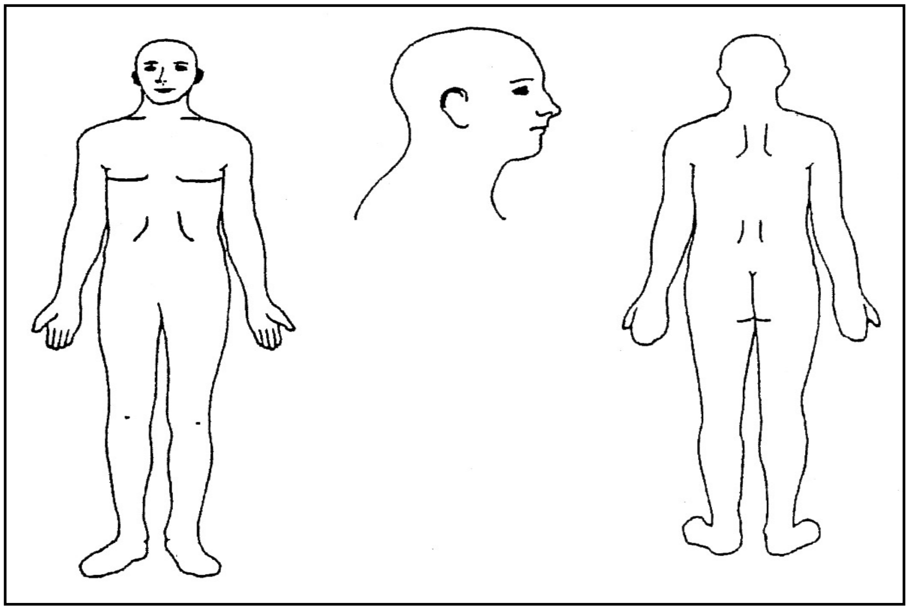
Office Use Only: Initial Findings:

PLEASE MARK AN X ON THE DIAGRAM
BELOW WHERE YOUR PROBLEMS ARE



What hurts and how long has it hurt?
On a scale of 1 to 10, 10 being the worst possible pain how would you rate it today?

1. ____Pain/Stiffness/Numbness Rating______
2. ____Pain/Stiffness/Numbness Rating______
3. ____Pain/Stiffness/Numbness Rating______
4. ____Pain/Stiffness/Numbness Rating______

When do you think these problems originally started?

1. ____
2. ____
3. ____
4. ____

This issue affects my (please circle what applies):
Job, Childcare, Marriage, Sex, Golf, Finances, Playing with my kids, Bowels, Urine, Mood, Exercise, School**.**

Please give the Doctor any additional conditions or situations that you might also be dealing with other then the problem mentioned above. Please include all current health issues.____
____
____
____
____

Notice of privacy for:
Patients Protected Health Information

This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office abides by the terms described in this policy:

This office uses and discloses your protected health care information for the following reasons:

- To share with other treating health care providers regarding your health care.
- To submit to insurance companies or Workers Compensation or No Fault to verify that treatment has been rendered.
- To determine patients benefits in a healthcare plan.
- Releasing information required by State or Federal Public Health Law.
- To assist in overcoming a language barrier when caring for a patient.
- Business Associates providing written assurances for your privacy have been obtained.
- Emergency situations.
- Abuse, neglect, or domestic violence.
- Appointment reminders to household members or answering machines.
- Sign-in logs may be disclosed to verify office visits.
- To send out birthday cards, postcards, reminders, or newsletters.
- We have open treatment arrangement to keep office flow efficient so that you can be serviced in timely manner.
- With consent to use your success story for advertising purposes, whether print, audio, video, or world wide web.

Any other uses or disclosures will only be made with your specific written prior authorizations.

You have the right to:

- Revoke authorization, in writing at any time by specifying what you want restricted and to whom.
- Speak to our privacy officer who is Lisa and can be reached at Gucciardo Specific Chiropractic regarding privacy issues.
- Inspect, copy, and amend your protected health information and amend it as allowed by law.
- Obtain an accounting of disclosures of your protected health information.
- To render a complaint to our privacy officer.

This office reserves the right to change the terms of this notice and make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received and reviewed this notice with full understanding.

___________________________	___________________________________	_____________
Name of Patient	Signature of Patient or Legal Representative	Date