

EAST END SPORTS CHIROPRACTIC

STEPHEN J. PETRUCCELLI, DC, CCSP, CSCS

REGISTRATION FORM**Please print. All fields marked with * MUST be completed.**

Today's date:

PATIENT INFORMATION

First Name:	Middle:	Last:	Birth Date*: / /	Social Security Number:
Mailing Address:		City:		State: Zip:
Home Phone: ()	Cell Phone: ()	Work Phone: ()	Email: @	
Marital status (circle one) Single / Married / Domestic Partner / Divorced / Separated / Widow(er)				Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Occupation:	Employer:		Employer phone no.: ()	
Whom may we thank for referring you?				
In case of emergency, who should be notified:	Relationship to patient:	Home Phone: ()	Work Phone: ()	

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for account:	Birth date: / /	Social Security Number:		
Address (if different):		Home Phone: ()		
Relationship to Patient:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other
Insurance Company:	Member #:		Group # (if any):	
Secondary Insurance(if applicable):	Subscriber's Name:	Group Number:	Policy Number:	
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other

ASSIGNMENT AND RELEASE

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize East End Sports Chiropractic or insurance company to release any information required to process my claims.

*Patient/Guardian signature**_____
*Date**

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HEALTH QUESTIONNAIRE

(Please Complete All Information)

Today's date:

Patient's First Name:	Middle Initial:	Last Name:
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PATIENT CONDITION

Reason for visit:

When did your symptoms first appear?

Is this condition getting worse? Yes No Unknown

Rate the severity of your pain, if you have pain (circle one):
0 1 2 3 4 5 6 7 8 9 10
No Pain Severe

Type of pain / symptoms (circle all that apply):
Sharp Dull Throbbing Aching Shooting Burning
Cramping Numbness Swelling Tingling Stiffness Other _____

Does the pain / symptoms interfere with your (circle all that apply):
Work Sleep Daily Routine Recreation

Which, if any, activities / movements are painful or cause symptoms (circle all that apply):
Sitting Standing Walking Bending Lying Down

ACCIDENT INFORMATION

If this condition is due to an accident, what was the date of the accident? / /

Type of accident:
 Auto Work Home Other _____

To whom have you made a report of the accident?
 Auto Insurance Employer Workers Comp Other _____

Attorney's Name (if applicable):

HEALTH HISTORY

What treatment have you already received for this condition?
 Medication Surgery Physical Therapy Chiropractic None Other _____

Name(s) of doctor(s) who have already treated you for this condition:

Do you have a pacemaker or any steel pins / rods / screws / etc. implanted anywhere in your body?
 No Yes, describe _____

Do you have any replacement joints?
 No Yes. Where? _____

How many hours of sleep do you normally get? _____ hours per night

Type of pillow used? Thin Thick Support/Orthopedic

Do you sleep on your Back Side Stomach

Do you wear: Orthotics, describe _____ Shoe Lifts Arch Supports Heel lifts

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HEALTH QUESTIONNAIRE

(Please Complete All Information)

GENERAL SYMPTOMS

Please check symptoms that you currently have or have had in the past year.

GENERAL	GASTROINTESTINAL	CARDIOVASCULAR	EYE, EAR, NOSE, THROAT
<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Appetite Poor	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Bleeding Gums
<input type="checkbox"/> Chills	<input type="checkbox"/> Bloating	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Blurred Vision
<input type="checkbox"/> Dental Problems	<input type="checkbox"/> Bowel Changes	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Crossed Eyes
<input type="checkbox"/> Depression	<input type="checkbox"/> Constipation	<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Difficulty Swallowing
<input type="checkbox"/> Difficulty Sleeping	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Double Vision
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Excessive Hunger	<input type="checkbox"/> Rapid Heart Beat	<input type="checkbox"/> Earache
<input type="checkbox"/> Fainting	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Swelling of Ankles	<input type="checkbox"/> Ear Discharge
<input type="checkbox"/> Fever	<input type="checkbox"/> Gas	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Hemorrhoids		<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Headache	<input type="checkbox"/> Indigestion		<input type="checkbox"/> Loss of Hearing
<input type="checkbox"/> Loss of Sleep	<input type="checkbox"/> Nausea		<input type="checkbox"/> Nosebleeds
<input type="checkbox"/> Loss of Weight	<input type="checkbox"/> Rectal Bleeding		<input type="checkbox"/> Persistent Cough
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Stomach Pain		<input type="checkbox"/> Ringing in Ears
<input type="checkbox"/> Numbness	<input type="checkbox"/> Vomiting		<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Sweats	<input type="checkbox"/> Vomiting Blood		<input type="checkbox"/> Vision-Flashes
<input type="checkbox"/> Tiredness			<input type="checkbox"/> Vision-Halos
<input type="checkbox"/> Weight Gain			
<input type="checkbox"/> Weight Loss			
	GENITO-URINARY	SKIN	
	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Bruise Easily	
	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Hives or Allergies	
	<input type="checkbox"/> Lack of Bladder Control	<input type="checkbox"/> Itching	
	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Change in Moles	
		<input type="checkbox"/> Rash	
		<input type="checkbox"/> Scars	
		<input type="checkbox"/> Sore that won't heal	

GENERAL SYMPTOMS-MEN ONLY

<input type="checkbox"/> Lump in Testicles	<input type="checkbox"/> Erection Difficulties	<input type="checkbox"/> Chest/Breast Lump	<input type="checkbox"/> Penis Discharge
<input type="checkbox"/> Sore on Penis	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

GENERAL SYMPTOMS-WOMEN ONLY

<input type="checkbox"/> Abnormal Pap Smear	<input type="checkbox"/> Bleeding between periods	<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Extreme Menstrual Pain
<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Nipple Discharge	<input type="checkbox"/> Painful Intercourse	<input type="checkbox"/> Vaginal Discharge
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	

Date of last period / /

Are you pregnant?

Have you entered menopause?

No

Yes Since (year):

HEALTH QUESTIONNAIRE

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(Please Complete All Information)

BACK, NECK, EXTREMITIES

Please check symptoms you currently have or have had in the past year.

NECK

- Pain in neck
- Neck stiffness
- Neck weakness
- Pinched nerve in neck
- Pain shooting from neck down arm (s)
- Muscle spasms
- Grinding/popping sounds in neck

MID-BACK

- Mid-back pain
- Mid-back stiffness
- Pain between shoulder blades
- Pain from front to back
- Muscle spasms

LOW-BACK

- Low back pain
- Low back stiffness
- Low back weakness
- Pinched nerve in low back
- Pain shooting down back of leg(s)
- Muscle spasms in low back

Please indicate if symptom(s) occur in the left side, right side or both.

HIPS, LEGS & FEET

- Pain in buttocks
- Pain in hip joints
- Pain down leg
- Pain in knee
- Pain in ankle
- Pain in foot
- Weakness of leg
- Weakness of knees
- Leg cramps
- Numbness in legs
- Numbness in feet

LEFT RIGHT

ARMS & HANDS

- Pain in upper arm
- Pain in elbow
- Pain in forearm
- Pain in hand
- Pain in fingers
- Pins & needles in arm
- Pins & needles in fingers
- Numbness in arm
- Numbness in fingers
- Weakness in arm
- Weakness in hand
- Hands cold
- Drop things/weak grip

LEFT RIGHT

SHOULDERS

- Pain in shoulder joint
- Pain across shoulders
- Can't raise arm above shoulder level
- Can't raise arm over head
- Tension in shoulders
- Pain in front of shoulder/arm

RELEASE

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

*Patient/Guardian signature**

*Date**

Received by Doctor

Date

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**New Patient Consent to the Use and Disclosure of Health Information
for Treatment, Payment, or Healthcare Operations**

I, _____, understand that as part of my health care, EAST END SPORTS CHIROPRACTIC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. **I understand that I have the following rights and privileges:**

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that EAST END SPORTS CHIROPRACTIC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should EAST END SPORTS CHIROPRACTIC change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

N/A or None

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

Patient's Signature*

Date*

FOR OFFICE USE ONLY

- [] Consent received by _____ on _____.
- [] Consent refused by patient, and treatment refused as permitted.
- [] Consent added to the patient's medical record on _____.