EAST END SPORTS CHIROPRACTIC

STEPHEN J. PETRUCCELLI, DC, CCSP, CSCS

REGISTRATION FORM

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Social Security Number:

Mailing Address:	City:	State:	Zip:

Home Phone: ( )	Mobile Phone: ( )	Work Phone: ( )	Email Address: @

Marital status (circle one) Single / Mar / Domestic Partner / Div / Sep / Widow(er)	Birth date: / /	Age:	Sex: ❑ M ❑ 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 no.: ( )	Work phone no.: ( )

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: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insurance Company:	Member #:	Group # (if any):

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ 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_

EAST END SPORTS CHIROPRACTIC

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HEALTH QUESTIONAIRE

(Please Complete All Information)

Today's date:

Patient's last name:	First:	Middle:

Marital status (circle one) Single / Mar / Domestic Partner / Div / Sep / Widow(er)	Birth date: / /	Age:	Sex: ❑ M ❑ F

Occupation:	Employer:

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 QUESTIONAIRE

(Please Complete All Information)

HEALTH HISTORY CONTINUED

Please list any medications you are currently taking.

Have you ever been hospitalized?	❑ No	❑ Yes for	
Have you ever had surgery?	❑ No	❑ Yes for	
Do you have any children?	❑ No	❑ Yes	How many? __________

Names and ages of children:

Do you have an immediate family history of (please check all that apply):

❑ Diabetes ❑ Heart Disease ❑ Stroke ❑ Cancer

Is yes, please explain

Do you have any allergies?	❑ No	❑ Yes, I am allergic to: _________________________
Do you smoke?	❑ No	❑ Yes, packs per day
Do you drink alcohol?	❑ No	❑ Yes, drinks per day
Do you use any recreational drugs?	❑ No	❑ Yes, explain
Do you exercise regularly?	❑ No	❑ Yes, times per week

What type of exercise do you do? ____

Please check if you have had, or currently have, any of the following:

❑ AIDS	❑ Diabetes	❑ Liver Disease	❑ Rheumatic Fever
❑ Alcoholism	❑ Emphysema	❑ Measles	❑ Scarlet Fever
❑ Anemia	❑ Epilepsy	❑ Migraine Headaches	❑ Stroke
❑ Anorexia	❑ Glaucoma	❑ Mononucleosis	❑ Suicide Attempts
❑ Appendicitis	❑ Goiter	❑ Multiple Sclerosis	❑ Thyroid Problems
❑ Arthritis	❑ Gonorrhea	❑ Mumps	❑ Tonsillitis
❑ Asthma	❑ Gout	❑ Osteoporosis	❑ Tuberculosis
❑ Bleeding Disorders	❑ Heart Disease	❑ Pacemaker	❑ Tumors, Growths
❑ Breast Lump	❑ Hepatitis	❑ Parkinson's Disease	❑ Typhoid Fever
❑ Bronchitis	❑ Hernia	❑ Pinched Nerve	❑ Ulcers
❑ Bulimia	❑ Herniated Disc	❑ Pneumonia	❑ Vaginal Infections
❑ Cancer	❑ Herpes	❑ Polio	❑ Venereal Disease
❑ Cataracts	❑ High Cholesterol	❑ Prostate Problem	❑ Whooping Cough
❑ Chemical Dependency	❑ HIV Positive	❑ Prosthesis	❑ Other __________________
❑ Chicken Pox	❑ Kidney Disease	❑ Psychiatric Care	❑ Other __________________
❑ Fractures	❑ Miscarriages	❑ Rheumatoid Arthritis	❑ Other __________________

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HEALTH QUESTIONAIRE

(Please Complete All Information)

GENERAL SYMPTOMS

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

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

GENERAL SYMPTOMS-MEN ONLY

❑ Lump in Testicles	❑ Erection Difficulties	❑ Chest/Breast Lump	❑ Penis Discharge
❑ Sore on Penis	❑ Other ___________________	❑ Other ___________________	❑ Other ___________________

GENERAL SYMPTOMS-WOMEN ONLY

❑ Abnormal Pap Smear	❑ Bleeding between periods	❑ Breast Lump	❑ Extreme Menstrual Pain
❑ Hot Flashes	❑ Nipple Discharge	❑ Painful Intercourse	❑ Vaginal Discharge
❑ Other ___________________	❑ Other ___________________	❑ Other ___________________	

Date of last period / /

Are you pregnant?

Have you entered menopause? ❑ No ❑ Yes Since (year):

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HEALTH QUESTIONAIRE

(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
- ❑ Neck feels out of place
- ❑ 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
- ❑ Low back feels out of place
- ❑ Muscle spasms in low back

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

HIPS, LEGS & FEET	LEFT	RIGHT
❑ 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		

SHOULDERS	LEFT	RIGHT
❑ Pain in shoulder joint		
❑ Pain across shoulders		
❑ Can't raise arm above shoulder level		
❑ Can't raise arm over head		
❑ Tension in shoulders		
❑ Pinched nerve in shoulder		

ARMS & HANDS	LEFT	RIGHT
❑ 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		

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:

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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 ________________________________.