Personal Information

DiMartino Chiropractic

Name:	DOB: / /	Age:
Address:	City:	
State:	Zip:	Email:
Home Phone:	Cell Phone:	
Preferred method of communication for appointment reminders (circle one): email / text		
If text - who is your cell phone provider?		
❑ Married ❑ Widowed ❑ Divorced ❑ Single	Number of children and ages:	
Employer :	Occupation:	
How did you hear about us?		
Have you ever been to a chiropractor before? Yes / No Last visit? Good results?		
Have you ever been told you have any problems in your spine or nervous system? Yes / No		
If yes, explain:		
Females: Pregnant? Yes / No Due date:		
Race (circle one): American Indian or Alaska Native / Asian / Black or African American / Hispanic or Latino / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / I Decline to Answer		

Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be make only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request
- You may request to view changes to your records
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and/or disclosed.

Patient Name (printed):	Signature:	Date:
Minor - Parent Signature of patient under age of 18:		Date:
Would you like to authorize other person(s) to have access to your health records? Yes / No		
If yes, please state name of person(s):		

Symptoms

Please note that it's through your input that we are able to document medical necessity for your insurance. This is important because your insurance company may deny coverage for you if we cannot document medical necessity. Please help us by providing as much detail as possible.

1) Neck problem: ❑ Yes ❑ No **(If no, skip to #2)**

What caused the neck problem?
When did the problem begin?
How would you describe the amount of time that you experience the neck problem? ❑ Constant (75-100%) ❑ Frequent (50-75%) ❑ Intermittent (25-50%) ❑ Occasional (0-25%)
Type of problem: ❑ Dull ❑ Sharp ❑ Achy ❑ Stiffness ❑ Numbness ❑ Other_____
Does the symptom radiate? Yes / No If yes, where to?
Severity (circle one): 1 2 3 4 5 6 7 8 9 10 (10 being worst)
What makes it better?
What makes it worse?
What treatment have you already received for the neck problem? ❑ Medications ❑ Surgery ❑ Physical Therapy ❑ Chiropractic ❑ None ❑ Other_____

2) Mid-back problem: ❑ Yes ❑ No **(If no, skip to #3 on next page)**

What caused the mid-back problem?
When did the problem begin?
How would you describe the amount of time that you experience the mid-back problem? ❑ Constant (75-100%) ❑ Frequent (50-75%) ❑ Intermittent (25-50%) ❑ Occasional (0-25%)
Type of problem: ❑ Dull ❑ Sharp ❑ Achy ❑ Stiffness ❑ Numbness ❑ Other_____
Does the symptom radiate? Yes / No If yes, where to?
Severity (circle one): 1 2 3 4 5 6 7 8 9 10 (10 being worst)
What makes it better?
What makes it worse?
What treatment have you already received for the mid-back problem? ❑ Medications ❑ Surgery ❑ Physical Therapy ❑ Chiropractic ❑ None ❑ Other_____

Symptoms

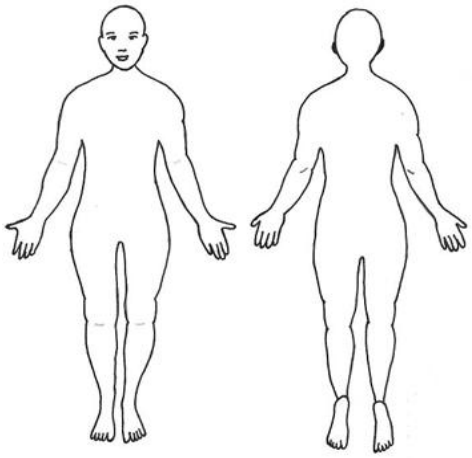
3) Low back problem: ❑ Yes ❑ No **(If no, skip to #4)**

What caused the low back problem?
When did the problem begin?
How would you describe the amount of time that you experience the low back problem? ❑ Constant (75-100%) ❑ Frequent (50-75%) ❑ Intermittent (25-50%) ❑ Occasional (0-25%)
Type of problem: ❑ Dull ❑ Sharp ❑ Achy ❑ Stiffness ❑ Numbness ❑ Other_____
Does the symptom radiate? Yes / No If yes, where to?
Severity (circle one): 1 2 3 4 5 6 7 8 9 10 (10 being worst)
What makes it better?
What makes it worse?
What treatment have you already received for the low back problem? ❑ Medications ❑ Surgery ❑ Physical Therapy ❑ Chiropractic ❑ None ❑ Other_____

4) Any other problem?: ❑ Yes ❑ No **If yes, what?**

What caused this problem?
When did this problem begin?
How would you describe the amount of time that you experience this problem? ❑ Constant (75-100%) ❑ Frequent (50-75%) ❑ Intermittent (25-50%) ❑ Occasional (0-25%)
Type of problem: ❑ Dull ❑ Sharp ❑ Achy ❑ Stiffness ❑ Numbness ❑ Other_____
Does the symptom radiate? Yes / No If yes, where to?
Severity (circle one): 1 2 3 4 5 6 7 8 9 10 (10 being worst)
What makes it better?
What makes it worse?
What treatment have you already received for this problem? ❑ Medications ❑ Surgery ❑ Physical Therapy ❑ Chiropractic ❑ None ❑ Other_____

Mark an X on the picture anywhere you have pain, numbness, or tingling



Review of Systems

Have you ever suffered from? (check all that apply)

1) Musculoskeletal

❑ Arthritis ❑ muscle cramping ❑ neck problems ❑ shoulder problems ❑ elbow/wrist pain ❑ mid-back problems
❑ low back problems ❑ knee problems ❑ foot/ankle pain ❑ hip problems ❑ gout ❑ joint or muscle pain/stiffness
❑ osteoporosis ❑ scoliosis

2) Neurological

❑ anxiety and/or panic ❑ depression ❑ difficulty concentrating ❑ dizziness ❑ epilepsy/seizures ❑ memory issues
❑ numbness ❑ pins and needles ❑ sleeping issues ❑ stroke ❑ temporary loss of vision, smell or hearing
❑ weak muscles ❑ hand/arm numbness ❑ leg/foot numbness

3) Head, Eyes, Ears, Nose and Throat

❑ cataracts ❑ chronic ear infections ❑ difficulty swallowing ❑ frequent colds ❑ allergies ❑ ear or hearing problems
❑ ear ache ❑ eye or vision problems ❑ eye surgery ❑ eyeglasses/contact lenses ❑ glaucoma ❑ headaches/migraines
❑ nose congestion or sinus trouble ❑ ringing in the ears ❑ sore throat ❑ TMJ problems

4) Cardiovascular

❑ blood clots ❑ chest pain or tightness ❑ congenital heart defects ❑ coronary artery disease ❑ dizziness
❑ excessive bruising ❑ heart attack ❑ heart murmur ❑ high blood pressure ❑ high cholesterol or triglycerides
❑ leg pain upon walking ❑ low blood pressure ❑ lower extremity swelling ❑ palpitations ❑ rheumatic fever
❑ varicose veins

5) Respiratory

❑ apnea ❑ asthma ❑ emphysema ❑ hay fever ❑ persistent cough ❑ pneumonia ❑ shortness of breath
❑ snoring issues ❑ tuberculosis ❑ wheezing

6) Gastrointestinal

❑ abdominal pain ❑ black or bloody stool ❑ bloating ❑ colitis ❑ colon cancer or colon polyps ❑ constipation
❑ Crohn's disease ❑ difficulty swallowing ❑ food sensitivities ❑ gastric reflux ❑ heartburn ❑ hemorrhoids
❑ Irritable bowel syndrome ❑ jaundice ❑ liver disease ❑ nausea or vomiting ❑ pancreatitis ❑ severe diarrhea
❑ ulcer

7) Genitourinary

❑ blood in the urine ❑ incontinence ❑ kidney stones ❑ painful or frequent urination ❑ urgency ❑ urinary infections
❑ sexual dysfunction ❑ prostate problems

8) Endocrine

❑ Cushing's syndrome ❑ diabetes ❑ cancer ❑ excessive thirst ❑ feeling hot or cold all the time ❑ hyperparathyroidism
❑ hyperthyroidism ❑ hypothyroidism ❑ increase size of hands or feet ❑ cold extremities ❑ fatigue
❑ menstrual problems ❑ increased urination ❑ pancreatic conditions ❑ testosterone deficiency ❑ thyroid problems

9) Dermatological or Hematopoietic

❑ change in hair or nails ❑ easy bruising ❑ eczema ❑ excessive acne ❑ excessive hair loss ❑ flushing ❑ gum bleeding
❑ psoriasis ❑ skin cancer ❑ skin pigmentation issues ❑ skin trouble or rashes

Past, Family and Social History

List any surgeries you have had and the approximate dates which they occurred:

Are you currently taking any medications? (Include regularly used over-the-counter medications)	
Medication Name	Dosage and Frequency (i.e. 5mg once a day)

Do you have any medication allergies?	
Medication Name	Allergic Reaction

List any significant illnesses you have suffered from:

List any traumas and the approximate date which they occurred: (car accidents, falls, accidents, broken bones, etc)

Do you have a family history of:

❑ High blood Pressure ❑ Heart Disease ❑ Diabetes ❑ Back Problems

Work Activity: ❑ sitting ❑ standing ❑ light labor ❑ heavy labor
Alcohol: ❑ no alcohol ❑ less than 6 drinks/week ❑ more than 6 drinks/week
Smoking: ❑ light smoker ❑ heavy smoker ❑ ex-smoker ❑ never smoked
Caffeine: ❑ 1 cup per day ❑ 2 to 4 cups per day ❑ 5 or more cups per day ❑ no caffeine
Stress Level: ❑ low stress ❑ high stress

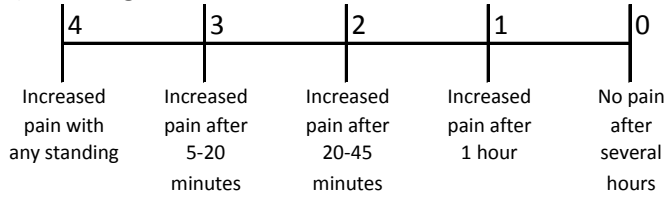
❑ I choose to decline receipt of my clinical summary after every visit (these summaries are often blank as a result of the nature and frequency of chiropractic care)

Patient Signature:	Date:

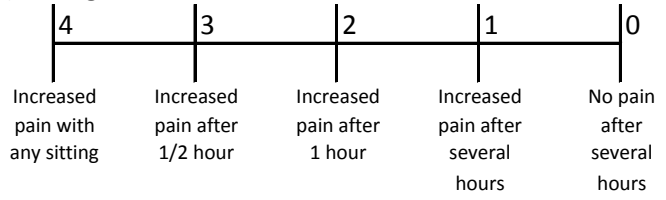
Functional Rating Index

In order to properly assess your condition, we must understand how much your neck or back problems have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

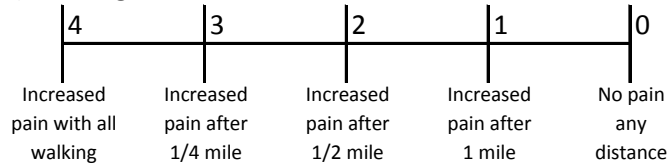
1) Standing



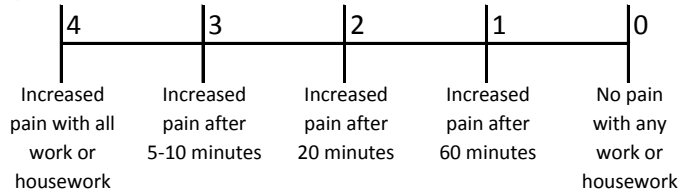
2) Sitting



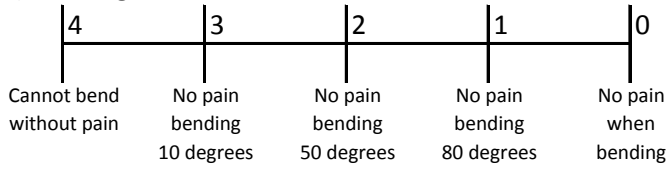
3) Walking



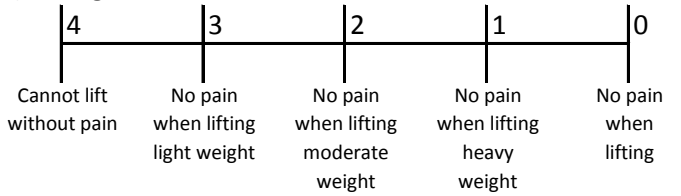
4) Work/Housework



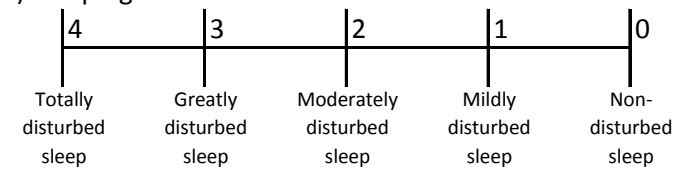
5) Bending



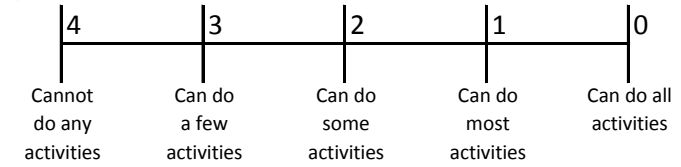
6) Lifting



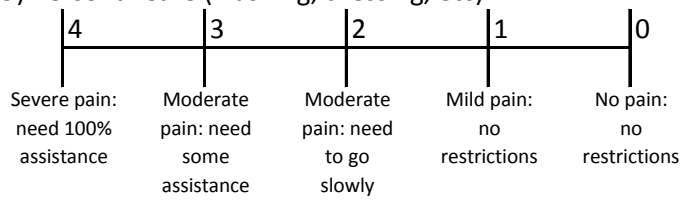
7) Sleeping



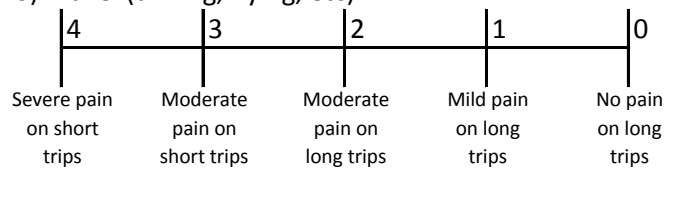
8) Recreation



9) Personal Care (washing, dressing, etc)



10) Travel (driving, flying, etc)



Total score:_____