D'IPPOLITO CHIROPRACTIC - Application for Care

Name _____________________, _____________________ ____
Last First MI

Address ____

________________ _____ _________ ______-______-______
City State Zip Code Social Security

__________________ __________________ _________________
Home Phone # Mobile # Work#

________ ________________ Sex: ❑Male ❑Female
Age Birth Date

E-Mail ____

How did you hear about us? __________________________

Employer ____

Occupation _______________________________________

Status S M W D Spouse's name _____________________
Kids? Y / N How many? __________________________

EMERGENCY INFORMATION

Name____

Phone # __________________ Relation ________________

Medical Dr. __________________ Phone _______________

Would you like us to send a copy of Dr. D'Ippolito's findings to you doctor? ____ Yes ____ No

Auto and work related injuries can cause serious spinal problems. Is this visit related to an accident or injury? ____ Date ___/___/___

Have you ever been treated by a chiropractor before? Y/N
When? ______________________Who?________________

FOR WOMEN ONLY

Spinal care is especially important during pregnancy.
Is there any chance that you are pregnant? ____Yes ____ No
Are you nursing Y/ N

WHAT BRINGS YOU TO OUR OFFICE?

#1) Pleas describe location of pain, or area of concern _______________________
____

Onset: ___/___/___ Type of pain ______ Sharp ______ Dull ______

Ache ______ Burn ______ Throb ______ Other ______

Does the pain radiate into your ______ Arm______ Legs______ Does not radiate

Do you experience numbness or tingling? ______ Yes ______ No

How often do you experience these symptoms ____ 100% ____ 50%
____ 25% ____10% of the time?

Right Left Left Right

Please mark the area of pain or area of concern.

On a scale of 0 to 10 (0 being no pain and 10 being unbearable) please rate your pain _______

What do you hope to do better or enjoy more when you regain your health? (Examples: recreation, work, home, play with children, sleep, etc..)
____

#2) Other complaint:____

Onset: ___/___/___ Type of pain ______ Sharp ______ Dull ______ Ache ______ Burn ______ Throb ______ Other ______

Does the pain radiate into your ______ Arm ______ Legs ______ Does not radiate

Do you experience numbness or tingling? ______ Yes ______ No
How often do you experience these symptoms ____ 100% ____ 50% ____ 25% ____10% of the time?

Please list all previous treatments for this condition: ____

Name of treating Physician ______________________________ Dates of treatment ______________

Type of treatment or drugs prescribed ____

Other treating Physician ______________________________ Dates of treatment ______________

Type of treatment or drugs prescribed ____

HEALTH HISTORY: Do any of the following diseases or conditions apply to you?

❑Yes ❑No Heart Attack/Stroke	❑Yes ❑No Heart Surg./Pacemaker	❑Yes ❑No Heart Murmer
❑Yes ❑No Congenital Heart Defect	❑Yes ❑No Mitral Valve Prolapse	❑Yes ❑No Artificial Valves
❑Yes ❑No Alcohol/Drug Abuse	❑Yes ❑No Venereal Disease	❑Yes ❑No Hepatitis
❑Yes ❑No HIV+/AIDS	❑Yes ❑No Shingles	❑Yes ❑No Cancer
❑Yes ❑No Emphysema/Glaucoma	❑Yes ❑No Anemia	❑Yes ❑No High/Low Blood Press.
❑Yes ❑No Psychiatric Problems	❑Yes ❑No Rheumatic Fever	❑Yes ❑No Kidney Problems
❑Yes ❑No Ulcers/Colitis	❑Yes ❑No Fainting/Seizures/Epilepsy	❑Yes ❑No Sinus Problems
❑Yes ❑No Asthma	❑Yes ❑No Diabetes/Tuberculosis	❑Yes ❑No Difficulty Breathing
❑Yes ❑No Chemotherapy	❑Yes ❑No Artificial Bones/Joints	❑Yes ❑No Arthritis

Please list any other serious **medical condition(s)** you have or have ever had:
____
____

Please list anything that you may be **allergic** to
____

Please list any previous **surgeries/treatments** with dates____
____

Is there a family history of any of the following? (Please circle all that apply) **CANCER, HEART DISEASE, STROKE, DIABETES, HIGH/LOW BLOOD PRESSURE**

What kind of Doctor are you looking for?

YES NO Most minimal amount of care to patch up your problem?
YES NO Resolve your symptoms and then go on to fix the problem?
YES NO Take care of your problem and then go on to achieve optimal health and wellness?

Account information-Person ultimately responsible for patient's account

I hereby authorize assignment of insurance rights and benefits directly to the provider for services rendered, I fully understand I am solely responsible for any balance not paid for by my insurance company. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider or managed care organization, to release any information needed to process insurance claims. The above information is true and accurate to the best of my knowledge.

Name: ______________________________________ Date: ______________

Fill out the following only if you are the parent or guardian of patient:
I hereby authorize assignment of insurance rights and benefits directly to the provider for services rendered, I fully understand I am solely responsible for any balance on this account not paid for by my insurance company.

Name: ________________________ Relationship to Patient ____________________

Offer not valid with any federal or state mandated insurance programs, or any insurance companies D'ippolito Chiropractic is contracted with .

If you are coming in for a Promotional FREE EXAM (G.S. 90-154.1):

Your exam will be free and any further services or treatments will be described prior to the service and may incur charges.
By signing, I agree that I am receiving FREE services and understand that I may incur charges for further treatment.

Name:______________________Witness:________________________