Welcome to Caruso Chiropractic

Today's Date:__________ File #:__________

Name, Last:____________________,First: ______________

What you Prefer To Be Called:__________ ☐ Male ☐ Female ☐ LGBTQ

Birth date:___/___/_____Age: ___ SS#: _______-______-________

Home Address:______________________________________

City____________________ State _____ Zip: __________

Cell Phone:______________ Email:____________________

Home Phone:______________

Referred By: ____

Employer: ______________________________ How Long? ___

Employer's Address: ______________________________

City: ______________________ State: _____ Zip: __________

Occupation:____________________

Martial Status: Single ☐ Married ☐ Divorced ☐ Seperated ☐ Widowed ☐

Spouse's Name:____

INSURANCE INFO

Company Name:______________________

Address:__________________________

Phone: ___________________________

Insured's SS#: _______-_______-__________

Group# (Plan, local or policy#) ______________________

Primary Care Physician:____________________

Address:__________________________

City:________________ St. ___ Zip ________

Insured's Name:____________________

Relation:__________ D.O.B ___/___/________

Insured's Employer:____________________

(Please inform front desk of 2nd Insurance Source)

EMERGENCY CONTACT

Contact Person:____________________

Relation:__________________________

Cell Phone:__________ Home: __________

Work:__________________

REASON FOR VISIT

Have you ever been treated by a chiropractor before? ☐ Yes ☐ No

If Yes, please explain: ____

The reason for this visit is a result of: work ☐ sports ☐ auto ☐ trauma ☐ chronic ☐ Other ____________

(Explain what happened):____

Please describe the pain & it's location:________________________________

When did condition begin?____________________________

Is this condition getting worse? Yes ☐ No ☐ Constant ☐ Comes and goes ☐

Is this condition interfering with your: work ☐ sleep ☐ daily routine ☐

If so, please explain:____

Have you had this or similar conditions in the past? Yes ☐ No ☐

If so, please explain:____

Have you been treated by a Medical Physician for this condition Yes ☐ No ☐

If so, please explain:____

- We invite you to discuss with us any questions regarding our services. The best health services are base on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made, in writing, with the business manager. If account is not paid within 90 days of the date of service and no finacial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature ________________________ Date ____________

CURRENT HEALTH HABITS

Did/do you smoke? .... Yes ☐ No ☐ If yes, Packs per day? ____ How long? _______

Did/do you drink alcohol? .... Yes ☐ No ☐ ______________________________

Have you been in accidents/tramna? ..... Yes ☐ No ☐ Explain ______________________________

Drugs, prescription, OTC, recreational?.. Yes ☐ No ☐ Explain ______________________________

Dental problems? .... Yes ☐ No ☐

Eye problems? .... Yes ☐ No ☐

Exercise regularly? .... Yes ☐ No ☐

Did/do you have occupational stress? ... Yes ☐ No ☐ Explain ______________________________

Physical stress? .... Yes ☐ No ☐ Explain ______________________________

Emotional/Mental stress? .... Yes ☐ No ☐ Explain ______________________________

Hobbies/Sports injuries? .... Yes ☐ No ☐ Explain ______________________________

Do you sleep well, hours of sleep? .... Yes ☐ No ☐ On ave.,how many hours a day? _______

Sleeping posture? Side ☐ Stomach ☐ Back ☐

Symptoms and Present State of Health

Reason for Seeking Care in this Office: Major ______________________________

Pain or Problem started on: ____________________

Pains are: Sharp ☐ Dull/Ache ☐ Constant ☐ Intermittent ☐ Other ☐ ______________________________

Does this pain shoot, radiate, or travel in your body? Yes ☐ No ☐ Where? ______________________________

Are you experiencing numbness or tingling in any area of your body? Where? ______________________________

Since it began, is it: Same ☐ Better ☐ Worse ☐

What activities aggravate your condition/pain? ______________________________

What activities lessen your condition/pain? ______________________________

Is this condition worse during certain times of the day? ______________________________

Is this condition interfering with Work ☐ Sleep ☐ Routine ☐ Other - Explain ______________________________

Is this condition progressively getting worse? Yes ☐ No ☐

Other Doctors seen for this condition ______________________________

Any home remedies? Yes ☐ No ☐ If Yes, explain ______________________________

Please mark any of the following conditions or symptoms that you have now or have experienced:

O Headache
O Neck Pain
O Sleeping Problems
O Low Back Pain
O Nervousness
O Tension
O Irritability
O Dizziness
O Pain Between Shoulders
O Neck Stiff
O Joint Swelling
O Fever
O Loss of Balance
O Ringing in Ears

O Jaw- TMJ Problems
O Pain in Hands or Arms
O Numbness in Hands or Arms
O Pain in Legs or Feet
O Numbness in Legs or Feet
O Fatigue
O Depression
O Lights Bother Eyes
O Loss of Memory
O Shoulder Pain
O Sinus
O Shortness of Breath
O Asthma
O Allergies

O Cold Hands
O Cold Feet
O Chest Pains
O High Blood Pressure O Stroke
O Cancer
O Painful Urination
O Diabetes
O Diarrhea
O Constipation
O Stomach Upset
O Heartburn/Reflux
O Weight Loss
O Loss of Smell or Taste
O Menstrual Cramps
O Menopause

Are you under medical care for any condition? ______________________________

What Medications are you taking? ______________________________

____

What surgeries have you had and when? ______________________________

What side effects have you experienced from the drugs and surgery? ______________________________

Females Only - Date last Menstrual Period began on: ____________ Are you possibly Pregnant? Yes ☐ No ☐

FAMILY HISTORY

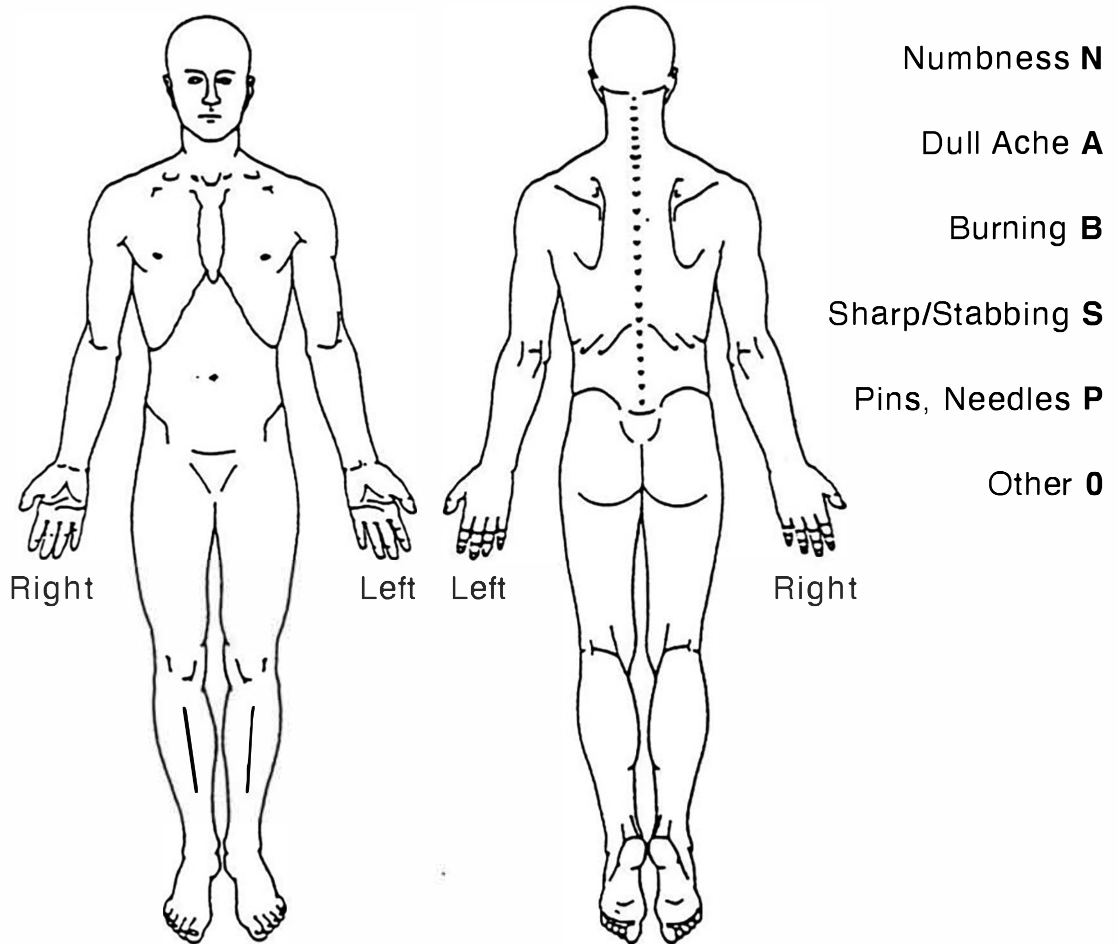
	Heart Disease	Arthritis	Cancer	Diabetes	Other ____________
Father's side	☐	☐	☐	☐	☐
Mother's side	☐	☐	☐	☐	☐

Signature ______________________ Date ___________

COMPLETE BY HAND AFTER PRINTING

Instructions:

On the body diagram below, please indicate where your pain is located at the present time.



Indicate on the line below how you would describe your present pain by placing a mark on the line between the two extremes of experiencing no pain at all and experiencing the worst pain you have ever felt.

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.

Signature ______________________________ Date ________________

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

______________________________ ____________________

Name of Patient Date

For further information regarding this notice, please contact our Doctor at (716) 832-8888.

INFORMED CONSENT

Patient's Name: ____

Clinic's Name: Caruso Chrirpractic

Doctor's Name: Dr. Anthony M. Caruso, DC

Address: 2577 Sheridan Drive Tonawanda, NY 14150

Phone: (716) 832-8888 Fax: (716) 832-0124

I will use my hands **or** a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should inform our office when you present this form.

DATE ________________________________

____
Printed Name

____
Signature

____
Signature of Parent / Guardian (if a minor)