PROACTIVE
CHIROPRACTIC REHABILITATION CENTER

Charles C. Annunziata, D.C.

Chiropractic • Rehabilitation • Nutrition

Confidential Patient Health Record

Today's Date ____/____/____

How did you hear about us? (Please mark all that apply) ☐ Family Friend ☐ Co-Worker (Please list name) _____
☐ Yellow Book ☐ Verizon Yellow pages (unknown) ☐ Close to home/work ☐ Drove by 369
☐ Online ☐ Web Page ☐ Screening ☐ Lecture ☐ Dr. _____

Personal Information 802

First: _____ Middle: _____ Last: _____ Sex: Male / Female

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____ County: _____ Country: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____ Fax # (_____) _____-_____

Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Birth Date: ____/____/____ Age: _____

Social Security # _____ Driver's License # _____ State: _____

Spouse Name: _____ Email Address: _____

Children (Names and Ages) _____

Emergency Contact

Name: _____ Phone Number: (_____) _____-_____

Address: _____

Relationship: ☐ Spouse ☐ Relative ☐ Friend ☐ Other _____

Current Health Condition

Unwanted Condition (Why you are here today?) _____

_____

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → →

When did this condition BEGIN? _____

Has it ever occurred before? ☐ Yes ☐ No When? _____

Is the Condition: ☐ Auto Related ☐ Job Related ☐ Home Injury

☐ Slip or Fall ☐ Lifting ☐ Slept Wrong ☐ Unknown Cause ☐ Other

Explain: _____

Date of Accident: _____/_____/_____ Time of Accident: _____ am/pm

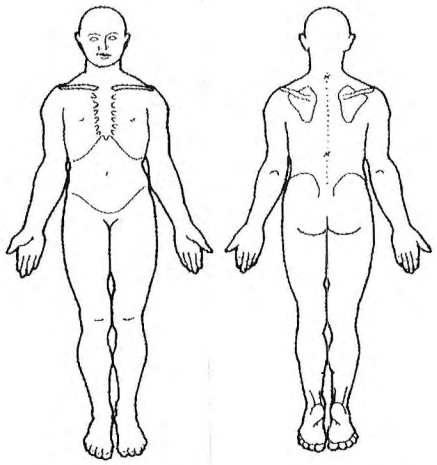
Condition/Pain STARTED ON WHAT Date: _____/_____/_____

Have you seen other doctors for THIS CONDITION? ☐ Yes ☐ No

If yes, who? (Name) _____

Use the letters BELOW to indicated the TYPE AND location of your sensations right now.

Key: A=Ache B=Burning N=Numbness



Type of Treatment: _____ Were you satisfied with the results of your treatment? ☐ Yes ☐ No

Explain: _____

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?

_____

PAST HEALTH HISTORY - Fill out carefully as these problems can affect your overall course of care.

Previous Chiropractic Care: ☐ I have not previously seen a Chiropractor OR Fill in the information BELOW.

Doctor's Name: _____ Location _____ Date of Last Visit: ____/____/____

Were you satisfied with your care: ☐ Yes ☐ No Why?: _____

Medications and Supplements

_____

_____

Adult Illness(es): LIST all health conditions. CIRCLE all CURRENT conditions.

_____

_____

Surgery(ies): LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.

_____

_____

Employment Information:

Business Name: _____ Occupation/Job Title _____

Address: _____ Name of Supervisor _____

Business Phone: (_____)_____-_____ Type of Work: _____

Insurance Information:

Who Is Responsible For Your Bill? YOU and . . . (mark appropriate box(es) ☐ Myself ONLY

☐ Spouse ☐ Worker's Comp ☐ Auto Insurance ☐ Medicare ☐ Medicaid ☐ Other (be specific): _____

Personal Health Insurance Carrier: _____ Health ID # _____ Group # _____

Policy Holders Name: _____ Policy Holders Date of Birth: _____/_____/____

Policy Holder's Social Security #: _____ Primary Care Physician: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Print Name: _____ Patient's Signature: _____ Date: ____/____/____

Consent to Treat a Minor: _____ Date: ____/____/____

Guardian or Spouse's Signature of Authorizing Care: _____ Date: ____/____/____

Don't Miss Out!!

Over 70% of our patients bring in their children to get adjusted. If you would like to have your children and or spouse evaluated, check the box below and they can each receive a complimentary examination including an adjustment on the ProAdjuster if scheduled within 2 weeks of your starting care. This exam is no cost to you and does not obligate them to receive future care. We have several convenient and affordable family plan payment options should family members decide to receive care.

☐ I would like my family members evaluated in the next two weeks.