CHIROPRACTIC PHYSICIANS GROUP

Joseph M. Valeriote, D.C. AnnaMarie F. Valeriote, D.C.

WELCOME TO OUR OFFICE!

DATE:_____

Patient Information

Name _____ SS#_____-_____-_____ Sex: ☐ M ☐ F
LAST FIRST M

Address_____ City_____ State_____ Zip_____

DOB_____ AGE_____ Home Ph#:_____ Other #:_____

Check Appropriate Box: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐Minor

Patient or Parent/Guardian's Employer:_____ BusPh#:_____

Co. Address:_____ City_____ State_____ Zip_____

Occupation_____ Email Address _____ State_____

Spouse's Name_____ Employer_____ Bus Ph#_____

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT?

Name_____ Ph#_____ Relationship_____

Primary Insurance

Name of Insured(on card)_____ Relationship to Patient_____

Address(if different from patient)_____ Ph#_____

InsuranceCo._____ Address_____

Group#_____ ID#_____ Ph#_____

Amount of Deductible? $_____ How much has been met? $_____ Max. Annual Benefits? $_____

Insured's Employer_____ Occupation_____ Date Employed_____

Bus.Ph#_____ Insured's SS#_____ Insured's DOB_____

Do you have any additional insurance? ☐YES ☐NO (If Yes, then complete the following Secondary Insurance section)

Secondary Insurance

Name of Insured(on card)_____ Relationship to Patient_____

Address(if different from patient)_____ Ph#_____

InsuranceCo._____ Address_____

Group#_____ ID#_____ Ph#_____

Amount of Deductible? $_____ How much has been met? $_____ Max. Annual Benefits? $_____

Insured's Employer_____ Occupation_____ Date Employed_____

Bus.Ph#_____ Insured's SS#_____ Insured's DOB_____

Assignment and Release

I hereby authorize Chiropractic Physicians Group, Dr's Joseph and/or AnnaMarie Valeriote, to release all information acquired in the course of my(or my child's) examination and/or treatment, to secure the payment of benefits. I hereby assign and grant the benefits that I am eligible to receive for professional services in this office rendered to Chiropractic Physician's Group. I understand that I am financially responsible for all those charges not paid for by my insurance. I authorize the use of this signature on all insurance submissions.

X_____ Relationship_____ Date_____

Signature of Patient (or parent/guardian if minor) (To patient)

HEALTH HISTORY

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Date: _____

Patient Name _____ Birthdate _____ Patient # _____

Chief Complaint: _____

History of present illness:

Location: _____
(Where is the pain/problem?)

Quality _____
(Example: normal versus abnormal color, activity, etc.)

Severity _____
(How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?)

Duration _____
(How long have you had this pain/problem?, or, When did it start?)

Timing _____
(Does the pain/problem occur at a specific time?)

Context _____
(Where were you at the onset of this pain/problem?)

Associated signs/symptoms _____
(What other associated problems have you been having?)

Modifying factors _____
(What makes the pain/problem worse or better?, or, Have you had previous episodes?)

Past Medical History

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles	no	yes	Anemia	no	yes	Back trouble	no	yes	Hepatitis	no	yes
Mumps	no	yes	Bladder Infections	no	yes	High Blood Pressure	no	yes	Ulcer	no	yes
Chickenpox	no	yes	Epilepsy	no	yes	Low Blood Pressure	no	yes	Kidney Disease	no	yes
Whooping Cough	no	yes	Migraine Headaches	no	yes	Hemorrhoids	no	yes	Thyroid Disease	no	yes
Scarlet Fever	no	yes	Tuberculosis	no	yes	Date of last chest x-ray			Bleeding Tendency	no	yes
Diphtheria	no	yes	Diabetes	no	yes	Asthma	no	yes	Any other disease	no	yes
Smallpox	no	yes	Cancer	no	yes	Hives or Eczema	no	yes	(please list):		
Pneumonia	no	yes	Polio	no	yes	AIDS or HIV+	no	yes			
Rheumatic Fever	no	yes	Glaucoma	no	yes	Infectious Mono	no	yes			
Heart Disease	no	yes	Hernia	no	yes	Bronchitis	no	yes			
Arthritis	no	yes	Blood or Plasma			Mitral Valve Prolapse	no	yes			
Venereal Disease	no	yes	Transfusions	no	yes	Stroke	no	yes			

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medications: (Include nonprescription) _____

_____

_____

Patient social history:

Marital status: Single:_____ Married:_____ Separated:_____ Divorced:_____ Widowed:_____

Use of alcohol: Never:_____ Rarely:_____ Moderate:_____ Daily:_____

Use of tobacco: Never:_____ Previously, but quit:_____ Current packs / day:_____

Use of drugs: Never:_____ Type/Frequency: _____

Excessive exposure at home or work to: Fumes:_____ Dust:_____ Solvents:_____ Air-borne Particles:_____ Noise:_____

Family medical history:

	Age	Diseases	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Spouse			
Children			

Review of Systems: Please indicate a sonal history below:

☐ **Constitutional Symptoms**
- Good general health lately .... No Yes
- Recent weight change ..... No Yes
- Fever ..... No Yes
- Fatigue ..... No Yes
- Headaches ..... No Yes

☐ **Eyes**
- Eye disease or injury ..... No Yes
- Wear glasses/contact lenses ... No Yes
- Blurred or double vision ..... No Yes

☐ **Ears/Nose/Mouth/Throat**
- Hearing loss or ringing ..... No Yes
- Earaches or drainage ..... No Yes
- Chronic sinus problem or rhinitis No Yes
- Nose bleeds ..... No Yes
- Mouth sores ..... No Yes
- Bleeding gums ..... No Yes
- Bad breath or bad taste ..... No Yes
- Sore throat or voice change ... No Yes
- Swollen glands in neck ..... No Yes

☐ **Cardiovascular**
- Heart trouble ..... No Yes
- Chest pain or angina pectoris .. No Yes
- Palpitation ..... No Yes
- Shortness of breath w/walking or lying flat ..... No Yes
- Swelling of feet, ankles or hands No Yes

☐ **Respiratory**
- Chronic or frequent coughs ... No Yes
- Spitting up blood ..... No Yes
- Shortness of breath ..... No Yes
- Wheezing ..... No Yes

☐ **Gastrointestinal**
- Loss of appetite ..... No Yes
- Change in bowel movements .. No Yes
- Nausea or vomiting ..... No Yes
- Frequent diarrhea ..... No Yes
- Painful bowel movements or constipation ..... No Yes
- Rectal bleeding or blood in stool No Yes
- Abdominal pain ..... No Yes

☐ **Genitourinary**
- Frequent urination ..... No Yes
- Burning or painful urination .... No Yes
- Blood in urine ..... No Yes
- Change in force of strain when urinating ..... No Yes
- Incontinence or dribbling ..... No Yes
- Kidney stones ..... No Yes
- Sexual difficulty ..... No Yes
- Male - testicle pain ..... No Yes
- Female - pain with periods .... No Yes
- Female - irregular periods ..... No Yes
- Female - vaginal discharge ..... No Yes
- Female - # of pregnancies .... _____
- Female - # of miscarriages .... _____
- Female - date of last pap smear _____

☐ **Musculoskeletal**
- Joint pain ..... No Yes
- Joint stiffness or swelling ..... No Yes
- Weakness of muscles or joints .. No Yes
- Muscle pain or cramps ..... No Yes
- Back pain ..... No Yes
- Cold extremities ..... No Yes
- Difficulty in walking ..... No Yes

☐ **Integumentary (skin, breast)**
- Rash or itching ..... No Yes
- Change in skin color ..... No Yes
- Change in hair or nails ..... No Yes
- Varicose veins ..... No Yes
- Breast pain ..... No Yes
- Breast lump ..... No Yes
- Breast discharge ..... No Yes

☐ **Neurological**
- Frequent or recurring headaches No Yes
- Light headed or dizzy ..... No Yes
- Convulsions or seizures ..... No Yes
- Numbness or tingling sensations No Yes
- Tremors ..... No Yes
- Paralysis ..... No Yes
- Head injury ..... No Yes

☐ **Psychiatric**
- Memory loss or confusion ..... No Yes
- Nervousness ..... No Yes
- Depression ..... No Yes
- Insomnia ..... No Yes

☐ **Endocrine**
- Glandular or hormone problem No Yes
- Excessive thirst or urination .... No Yes
- Heat or cold intolerance ..... No Yes
- Skin becoming dryer ..... No Yes
- Change in hat or glove size .... No Yes

☐ **Hematologic/Lymphatic**
- Slow to heal after cuts ..... No Yes
- Bleeding or bruising tendency .. No Yes
- Anemia ..... No Yes
- Phlebitis ..... No Yes
- Past transfusion ..... No Yes
- Enlarged glands ..... No Yes

☐ **Allergic/Immunologic**

History of skin reaction or other adverse reaction to:
- Penicillin or other antibiotics . No Yes
- Morphine, Demerol, or other narcotics ..... No Yes
- Novocain or other anesthetics No Yes
- Aspirin or other pain remedies No Yes
- Tetanus antitoxin or other serums ..... No Yes
- Iodine, Merthiolate or other antiseptic ..... No Yes
- Other drugs/medications: _____

Known food allergies: _____

Environmental allergies: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibilty to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of Patient, Parent or Guardian _____ Date _____

Doctor's Review

Signature of Doctor _____ Date _____

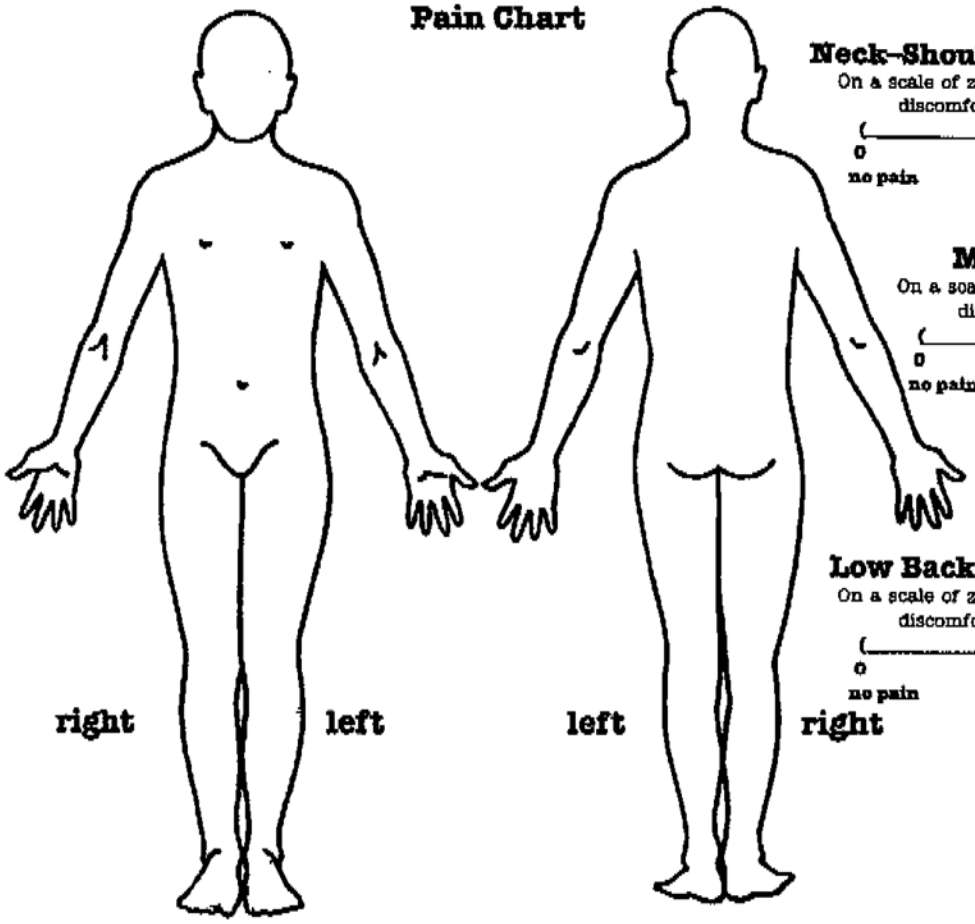
SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols.
Mark areas of radiation.
Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	00000	xxxxx	*****	/////
- - - - -	00000	xxxxx	*****	/////
- - - - -	00000	xxxxx	*****	/////

Please mark on the pain scale from Zero to 10 the pain you feel with this condition. 10 being the worst pain you have felt with this condition.

Pain Chart



Neck–Shoulder–Arm Pain
On a scale of zero to 10, I rate my discomfort as follows:
0 — 10
no pain — severe pain

Mid Back Pain
On a scale of zero to 10, I rate my discomfort as follows:
0 — 10
no pain — severe pain

Low Back and Leg Pain
On a scale of zero to 10, I rate my discomfort as follows:
0 — 10
no pain — severe pain

Date:_____

_____
Signature

Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed accomplish the task will be shared.

Who We May Use and Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment. We may use medical information about you to provide you with medical treatment or services.
Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment. We may use and disclosure medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to you insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To worker's compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution of law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare provider's treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' and healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Uses and Disclosure of Protected Health Information Requiring Your Written Authorization

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding Your Medical Information

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filling a complaint.

Right To Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about you care. Usually this includes medical and billing records but does not include psychotherapy notes, information complied for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may by used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied you request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to Privacy Officer at this practice. In addition, you must provide a reason that supports you request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statement of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized request for information pertaining to the appropriate portion of your record.

Right to an Accounting of Non-Standard Disclosures. You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit you request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date in the upper right corner of the first page.

Patient Signature _____