DePaolis Chiropractic Center
985 Belvidere Road
Phillipsburg, NJ 08865
(908) 859-1919
www.DePaolisChiropractic.com

PATIENT HISTORY

NAME ____

SOCIAL SECURITY #: ___/____/___

ADDRESS: ____

CITY: ____________________ STATE: ____ ZIP: _______

E-MAIL: ____

TODAY'S DATE: ___/___/___ DATE OF BIRTH: ___/____/___

MARITAL STATUS: S M D W SEP

SPOUSE / PARTNER'S NAME: _________________________

SPOUSE / PARTNER'S DATE OF BIRTH: ___/____/___

EMPLOYER: ____

PHONE: (H) _____________________ (CELL) _____________________ PHONE (W) _____________________ ext. _____

WHAT BRINGS YOU TO OUR OFFICE?

INSURANCE INFORMATION (PLEASE ANSWER ALL QUESTIONS)

- NAME OF INSURANCE COMPANY: ____
- GROUP NAME / NUMBER: ___________________________POLICY NUMBER: _____________________
- NAME OF INSURED: _____________________________________ DATE OF BIRTH: ____ / ____ / ____
- SOCIAL SECURITY NUMBER OF INSURED: _________---_________---_________
- DEDUCTIBLE AMOUNT: ______________ HAS THIS AMOUNT BEEN SATISFIED? YES ______ NO _______
- OTHER INSURANCE: ____
- IS CONDITION RELATED TO: WORK: _________ AUTO ACCIDENT: _________ OTHER: _________

  IF OTHER, PLEASE EXPLAIN: ____

IN CASE OF AN EMERGENCY, WHOM SHOULD WE NOTIFY: _______________________________________

PHONE NUMBER: ___________________ WHOM MAY WE THANK FOR REFERRING YOU: _________________________

COMPLAINT ____

- DATE SYMPTOM FIRST APPEARED: ____
- DID IT BEGIN: ______GRADUAL ______ SUDDEN _____ PROGESSIVE OVER TIME
- WHAT MAKES THE SYMPTOM INCREASE? ____
- WHAT RELIEVES THE SYMPTOM? ____
- TYPE OF PAIN: _____ SHARP _____ DULL ______ACHE ______BURN ______THROB
- DO YOU EXPERIENCE NUMBNESS OR TINGLING? _____ Y _______N
- HOW OFTEN DO YOU EXPERIENCE THESE SYMPTOMS?

  _____ 100% ________75% _________50% _________25% ____________10%

PAIN INTENSITY:

PLEASE PUT A LINE ON THE SCALE DESCRIBING THE INTENSITY OF YOUR PAIN

NO PAIN ——————————————————————————————-UNBEARABLE PAIN

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PATIENT HISTORY PART 2

PLEASE LIST ALL PREVIOUS TREATMENTS FOR THIS CONDITION:

NAME OF PRIMARY CARE PHYSICIAN: ____________________________________ TREATMENT DATES:_________

TYPE OF TREATMENT OR DRUGS PRESCRIBED: ____

____

____

NAME OF TREATING PHYSICIAN/SPECIALIST: _______________________________ TREATMENT DATES:_________

TYPE OF TREATMENT OR DRUGS PRESCRIBED: ____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? ______ YES ______ NO

NAME OF CHIROPRACTOR:____ DATES OF TREATMENT: ____________

REASON:____

____

____

PLEASE LIST ALL PAST SURGERIES:

TYPE: ____________________________________ DATE: ____________ DOCTOR: __________________________

TYPE: ____________________________________ DATE: ____________ DOCTOR: __________________________

TYPE: ____________________________________ DATE: ____________ DOCTOR: __________________________

TYPE: ____________________________________ DATE: ____________ DOCTOR: __________________________

PLEASE LIST ALL PREVIOUS ACCIDENTS AND FALLS:

TYPE: ____ DATE: _____________

TYPE: ____ DATE: _____________

TYPE: ____ DATE: _____________

TYPE: ____ DATE: _____________

PLEASE LIST ALL MEDICATIONS OR VITAMINS YOU ARE CURRENTLY TAKING:

TYPE: ____ FOR HOW LONG? ____________

TYPE: ____ FOR HOW LONG? ____________

TYPE: ____ FOR HOW LONG? ____________

TYPE: ____ FOR HOW LONG? ____________

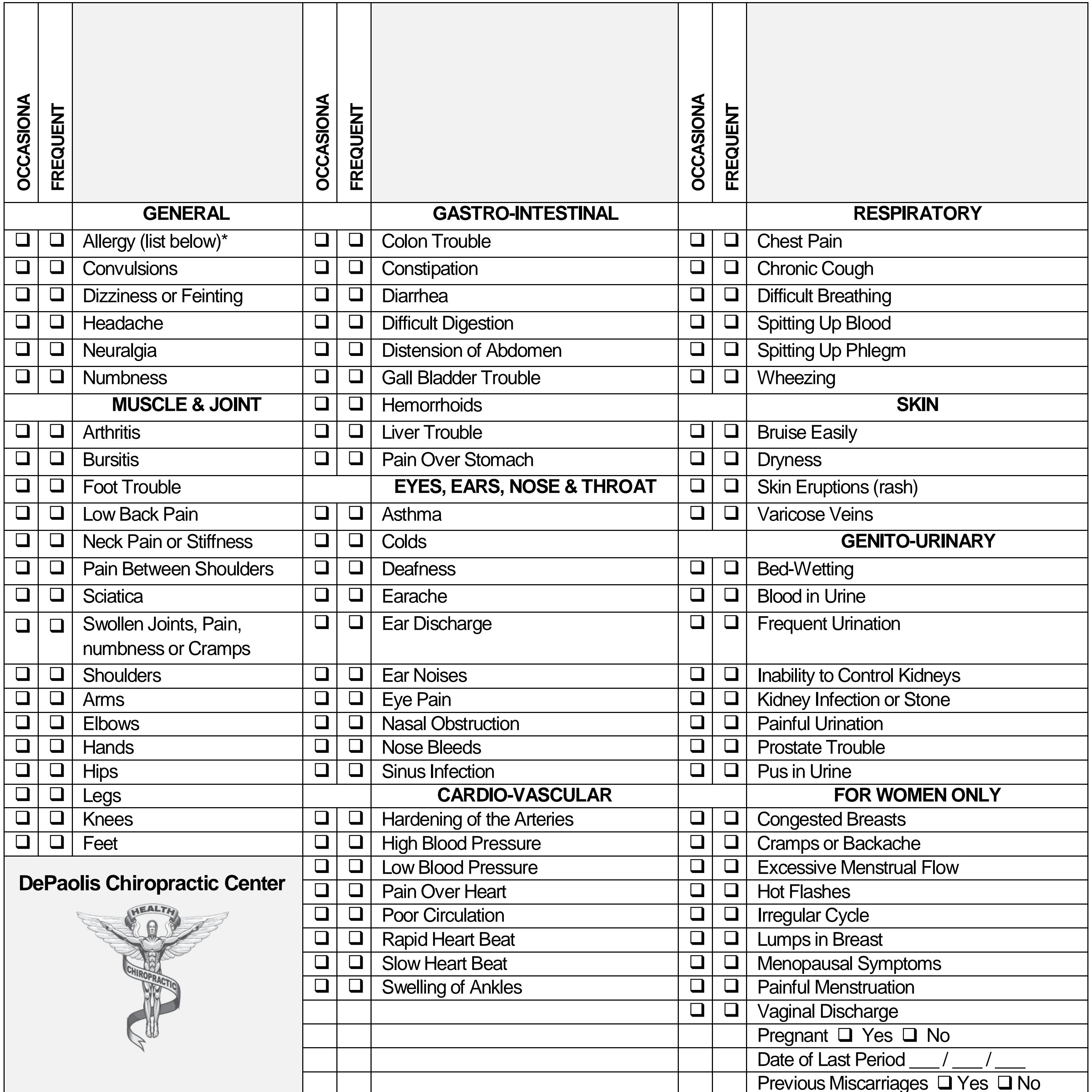
PATIENT SIGNATURE_______________________________________ **DATE** _____________

THIS IS A CONFIDENTIAL HEALTH REPORT

NAME: ____ BIRTH DATE: ___ / ___ / ___ DATE: _____________

HEIGHT: ______________________ WEIGHT: _____________________ SEX: ___M ____F CASE NO: ___________

PLEASE CHECK THE APPROPRIATE BOX FOR ANY TYPE OF THE FOLLOWING SYMPTOMS WHICH YOU NOW HAVE OR HAVE HAD PREVIOUSLY. WE WANT ALL THE FACTS ABOUT YOUR HEALTH BEFORE WE ACCEPT YOUR CASE. **THIS IS A CONFIDENTIAL HEALTH REPORT**.



OCCASIONA	FREQUENT		OCCASIONA	FREQUENT		OCCASIONA	FREQUENT	
		GENERAL			**GASTRO-INTESTINAL**			**RESPIRATORY**
❑	❑	Allergy (list below)*	❑	❑	Colon Trouble	❑	❑	Chest Pain
❑	❑	Convulsions	❑	❑	Constipation	❑	❑	Chronic Cough
❑	❑	Dizziness or Feinting	❑	❑	Diarrhea	❑	❑	Difficult Breathing
❑	❑	Headache	❑	❑	Difficult Digestion	❑	❑	Spitting Up Blood
❑	❑	Neuralgia	❑	❑	Distension of Abdomen	❑	❑	Spitting Up Phlegm
❑	❑	Numbness	❑	❑	Gall Bladder Trouble	❑	❑	Wheezing
		MUSCLE & JOINT	❑	❑	Hemorrhoids			**SKIN**
❑	❑	Arthritis	❑	❑	Liver Trouble	❑	❑	Bruise Easily
❑	❑	Bursitis	❑	❑	Pain Over Stomach	❑	❑	Dryness
❑	❑	Foot Trouble			**EYES, EARS, NOSE & THROAT**	❑	❑	Skin Eruptions (rash)
❑	❑	Low Back Pain	❑	❑	Asthma	❑	❑	Varicose Veins
❑	❑	Neck Pain or Stiffness	❑	❑	Colds			**GENITO-URINARY**
❑	❑	Pain Between Shoulders	❑	❑	Deafness	❑	❑	Bed-Wetting
❑	❑	Sciatica	❑	❑	Earache	❑	❑	Blood in Urine
❑	❑	Swollen Joints, Pain, numbness or Cramps	❑	❑	Ear Discharge	❑	❑	Frequent Urination
❑	❑	Shoulders	❑	❑	Ear Noises	❑	❑	Inability to Control Kidneys
❑	❑	Arms	❑	❑	Eye Pain	❑	❑	Kidney Infection or Stone
❑	❑	Elbows	❑	❑	Nasal Obstruction	❑	❑	Painful Urination
❑	❑	Hands	❑	❑	Nose Bleeds	❑	❑	Prostate Trouble
❑	❑	Hips	❑	❑	Sinus Infection	❑	❑	Pus in Urine
❑	❑	Legs			**CARDIO-VASCULAR**			**FOR WOMEN ONLY**
❑	❑	Knees	❑	❑	Hardening of the Arteries	❑	❑	Congested Breasts
❑	❑	Feet	❑	❑	High Blood Pressure	❑	❑	Cramps or Backache
DePaolis Chiropractic Center			❑	❑	Low Blood Pressure	❑	❑	Excessive Menstrual Flow
			❑	❑	Pain Over Heart	❑	❑	Hot Flashes
			❑	❑	Poor Circulation	❑	❑	Irregular Cycle
			❑	❑	Rapid Heart Beat	❑	❑	Lumps in Breast
			❑	❑	Slow Heart Beat	❑	❑	Menopausal Symptoms
			❑	❑	Swelling of Ankles	❑	❑	Painful Menstruation
						❑	❑	Vaginal Discharge
								Pregnant ❑ Yes ❑ No
								Date of Last Period ___ / ___ / ___
								Previous Miscarriages ❑ Yes ❑ No

DATE OF LAST: (Approx.)

________Physical Examination

________Blood Test

________Chest X-Ray

________Spinal X-Ray

_________Dental X-Ray

_________Urine Test

HAVE YOU EVER:

❑ Been Knocked Unconscious

❑ Used a crutch, or other support?

❑ Been treated for a spine or nerve disorder?

❑ Had a fractured bone?

❑ Been hospitalized? (other than surgery)

❑ Ever had surgery?

THIS IS A CONFIDENTIAL HEALTH REPORT (cont.)

Please fill in the table below:

NONE	LIGHT	MODERATE	HEAVY	
❑	❑	❑	❑	Alcohol
❑	❑	❑	❑	Coffee
❑	❑	❑	❑	Tobacco
❑	❑	❑	❑	Drugs
❑	❑	❑	❑	Exercise
❑	❑	❑	❑	Soft Drinks

Please list any prescription drugs now taken, allergies and past surgeries*____

____

____

____

CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAD:
CIRCLE ITEMS THAT ARE COMMON TO OTHER FAMILY MEMBERS

- ❑ AIDS
- ❑ Alcoholism
- ❑ Anemia
- ❑ Appendicitis
- ❑ Arteriosclerosis
- ❑ Cancer
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Eczema
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Foot Problems
- ❑ Goiter
- ❑ Gout
- ❑ Heart Disease
- ❑ Malaria
- ❑ Measles
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Pacemaker
- ❑ Pneumonia
- ❑ Polio
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Venereal Disease

After reading and filling out the case history, your signature will verify that all the information you have given us is accurate and that you have read the case history questions entirely,

______________________________ ______________________________ ______________
Name (printed) **Signature** **Date**

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PAIN DIAGRAM

Please mark the areas of your complaint on the diagram above.
Please use the following symbols to accurately describe your condition:

PPP - Where you experience PAIN
NNN - Where you experience NUMBNESS
TTT - Where you experience TINGLING
BBB - Where you experience BURNING
CCC - Where you experience CRAMPING

PATIENT SIGNATURE ______________________________ DATE ____________________

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DEPAOLIS CHIROPRACTIC CENTER

Privacy statement: In the course of your care with DePaolis Chiropractic Center, we may disclose personal and health information about you in the following ways:

-Your personal health information, including clinical records may be disclosed to another health care provider or hospital if it is necessity to refer you for further diagnosis, assessment or treatment.
-Your health care records as well as your billing records may be disclosed to another party such as insurance carrier, HMO, PPO or your employer if they are responsible for the payment of your services.
- Your name, address, phone number and health care records may be used to contact your regarding appointment reminders, birthday cards, and information about alternatives to your present care or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement associated with your care. Under federal law, we are also permitted or required to disclose your health information without your consent under the following circumstances:

-If we are providing health care service to you based on the order of another health care provider
-If we provide health care services to you in an emergency.
-If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
-If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
-If we are ordered to by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above will only be made upon your written authorization. We normally provide information about your health information for seven years from this date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing. You have the right to inspect and/ or copy your health information for 7 years from this date or as long as the information remains in our files. In addition you have the right to request an amendment to your health information in our files.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required by law to abide by the terms of this privacy notice. If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities, or if you would like further information about our privacy policies and practices, you should direct your complaints or questions to Dr. Robert H, DePaolis.

This notice is effective as of January 1, 2011. This notice and any alteration or amendments made hereto will expire 7 years from the date upon which the record was created.

My signature acknowledges that you have received a copy of this notice.

______________________	____________________________	______________
Name (printed)	**Signature**	**Date**

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.