Dr. Neal Pignatora D.C.

Patient Information

Date _____

Name _____

Address _____

City _____ State ___ Zip _____

Sex: Male Female Age _____ DOB _____

Occupation _____

Employer _____

Spouse's Name _____

Whom may we thank for referring you?

_____

Phone Numbers

Home _____ Work _____

Mobile _____

In case of emergency contact:

Name _____ Relationship _____

Home # _____ Work # _____

Accident Information

Is condition due to accident? Yes No Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?

Auto Ins. Employer Workers Comp. Other

_____

Patient Information

Who is responsible for this account? _____

Relationship to patient? _____

Insurance Comp. _____

ID # _____

Group # _____

Additional insurance? Yes No

Subscriber's Name _____

DOB _____ SS# _____

Relationship to patient? _____

Insurance Comp. _____

ID # _____

Group # _____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Pignatora all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Patient Condition

Reason for your visit _____

When did your symptoms first appear? _____

Is the condition getting progressively worse? Yes No Unknown

Rate the severity of your pain on a scale of 1 (least) to 10 (worst) 1 2 3 4 5 6 7 8 9 10

Type of pain: sharp dull throbbing numbness aching shooting

burning tingling cramps stiffness swelling other_____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does condition interfere with work daily routine recreation

Activities or movements that are painful to perform sitting standing walking bending

Previous treatment for your condition _____

Consent Form

State law requires us to obtain your consent prior to your chiropractic treatment. What you are being asked to sign is simply a confirmation that we have discussed your contemplated treatment and that we have given you sufficient information upon which to make a decision whether to have the treatment and any choice as to the type of treatment of your own free will. We will discuss with you the common problems or undesired results that sometimes occur. We wish to inform you, not alarm you. If you wish, however, we can go into more elaborate details of more unlikely problems. If you do not, that is also your privilege. Please read the form carefully. Ask about anything that you do not understand. We will be pleased to explain it. I hereby authorize and direct **Dr. Neal P. Pignatora III, DC**, to perform the following chiropractic procedures on:

_____

Patient Name Date

• The nature and purpose of the treatment to be performed by the physician are: Chiropractic Adjustment/ Therapy.
• These treatments are expected to accomplish: increase range of motion and decrease muscle spasms.
• The reasonably known risks of the treatments are: initial stiffness and discomfort.
• Details of this treatment and alternative methods of treatment have been explained to me. I have been advised that, although good results are expected, each situation/person reacts differently to the treatment; therefore, the outcome of the treatment has no guarantee as expressed or implied.
• The doctor has explained to me the most likely complications that may occur from this treatment and I understand them. I have also been told the less likely complications, even if rare, that could occur.
• I hereby authorize Dr. Neal P. Pignatora III and his associates/assistants to provide additional procedures) as they deem reasonable and.
• I hereby affirm and state that I have read and understood this consent and that all blanks were filled in prior to my signature.

Date_____
Signature _____
Witness_____

I certify that I have personally reviewed all the blanks on this form and explained them to the patient or his/ her representative before requesting the patient or his/her representative to sign this form.

_____

Physician Signature and Date

Memo to our Patients Regarding HIPAA

As you may know, a new law has been passed that relates to how we may use your personal health information. We have always been in the forefront regarding patient confidentiality; and, for years, have been very careful with how we share your information with other people and have tried to protect your privacy. So, you will probably not notice that this law with affect our interaction that much. We are required by law to have to sign a statement that you have received a copy of your rights under the law. This is called the "Notice of Privacy Practices". Please note that all of your records are stored in a secure site to ensure your privacy.

Please sign and date this page indicating that you have been allowed to read the "Notice of Privacy Practices" and were offered a paper copy if so desired.

_____

Signature of Patient
Date_____

HEALTH HISTORY

Please check all of the following signs and symptoms which you now have or have experienced in the last 6 months.

Neuromusculoskeletal
- Weakness
- Twitching
- Stiff neck
- Muscle spasm in neck
- Grating and/or grinding in neck
- Pain in shoulders and arms
- Tightening of shoulder muscles
- Pins and needles in arms/ hands
- Change in color or shape of nails
- Skin pain
- Cold hands
- Backache
- Swollen joints
- Painful joints
- Pain in legs
- Pins and needles in legs
- Foot trouble
- Cold feet
- Hernia
- Spinal curvature (scoliosis)

Eye, ears, nose and throat
- Poor vision
- Crossed eyes
- Pain in the eyes
- Deafness
- Earache
- Ringing in the ears
- Ear discharge
- Nasal obstruction
- Nose bleeds
- Sore throat
- Hoarseness
- Hay fever
- Asthma
- Frequent colds
- Tonsillitis

General Symptoms
- Headache
- Fever
- Chills
- Night sweats
- Fainting
- Dizziness
- Convulsions
- Loss of sleep
- Fatigue or weakness
- Nervousness
- Allergy
- Wheezing
- Neuralgia
- Cancer
- Arthritis
- Crying spells
- Frequent anger
- Trauma/ injuries
- Height changes
- Weight changes

Cardiovascular
- Rapid heart beat
- Slow heart beat
- High blood pressure
- Low blood pressure
- Pain over the heart
- Previous heart trouble
- Swelling of ankles
- Poor circulation
- Calf pain with walking
- Varicose veins
- Stroke
- Fainting

Respiratory
- Chronic cough
- Spitting blood
- Spitting phlegm
- Chest pain
- Difficulty breathing

Genitourinary
- Frequent urination
- Painful urination
- Blood in urine
- Change in urine color
- Pelvic pain
- Kidney infection
- Kidney disease
- Bladder infection
- Bed wetting
- Inability to control urine
- Prostate gland trouble
- STD
- Sexual difficulties

Gastrointestinal
- Poor appetite
- Change in appetite
- Poor digestion
- Ulcer
- Excessive hunger
- Belching or gas
- Indigestion/ heartburn
- Nausea
- Vomiting
- Vomiting blood
- Abdominal pain
- Constipation
- Change in stool
- Diarrhea
- Colon disease
- Hemorrhoids (piles)
- Liver trouble
- Jaundice
- Gall bladder difficulty
- Stomach trouble

Endocrine
- Hot or cold intolerance
- Thyroid problems
- Diabetes
- Neck surgery/ irradiation

Skin
- Skin eruptions
- Rashes/ itching
- Bruising
- Dryness
- Boils
- Sensitive skin
- Hives or allergies
- Eczema
- Psoriasis

Women only
- Pregnant at this time
- Painful periods
- Excessive flow
- Irregular cycles
- Hot flashes
- Cramps or backaches
- Miscarriage
- Vaginal discharge
- Painful breasts
- Breast lump or mass
- Breast implants
- Other

Family History
- Diabetes
- Cancer
- Thyroid disease
- Tuberculosis
- Seizures
- Allergies
- Heart disease
- Stroke
- Anemia
- High blood pressure
- Other

Tobacco or alcohol use

Smoking : _____

Alcohol: _____

	Description	Date
Previous falls, auto accidents or serious injuries	_____	_____
	_____	_____
Medications/ Allergies	_____	_____

Patient signature: _____ Date: _____