NEW HAVEN CHIROPRACTIC GROUP

Date: _____/_____/_____

Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

E-mail _____ Facebook _____

Birth Date _____/_____/_____ Age _____ Marital Status _____ ❑ Male ❑ Female

Employed by _____ Business Phone _____

Address _____ City _____ State _____ Zip _____

Alternate Contact (Name and Phone #) _____

Attorney Name _____ Last 4 digits of SS #_____

Do you have health insurance? ❑ Yes ❑ No If yes, list names _____

Do you have auto insurance? ❑ Yes ❑ No If yes, please provide a copy of your insurance cards to the receptionist

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How did this happen? ❑ Auto Accident ❑ Slip and Fall ❑ Workers Comp. ❑ Other _____

Date of Accident _____/_____/_____

Do you need transportation to our office? ❑ Yes ❑ No If yes, what dates? _____

Have you lost days from work? ❑ Yes ❑ No If yes, what dates? _____

IF INJURY IS RESULT OF A MOTOR VEHICLE ACCIDENT, PLEASE ANSWER THE FOLLOWING:

Were you the driver? ❑ Yes ❑ No Were you a passenger? ❑ Yes ❑ No

If you were a passenger, were you in the ❑ Front Seat ❑ Back Seat

What is the name of driver? _____

Were you wearing a seat belt? ❑ Yes ❑ No

Did an airbag inflate? ❑ Yes ❑ No

How were you hit? ❑ Rear-ended ❑ Head-on ❑ Broad-sided driver's side

❑ Broad-sided passenger side ❑ Other _____

Was your head turned at the time of impact? ❑ Yes ❑ No

Were you braced for impact? ❑ Yes ❑ No

Were you taken to an emergency room? ❑ Yes ❑ No

If yes, which one? _____

Were X-rays taken there? _____

Have you had any diagnostic testing done (MRI, CT Scan, X-rays, etc.)

❑ Yes ❑ No If yes, where? _____

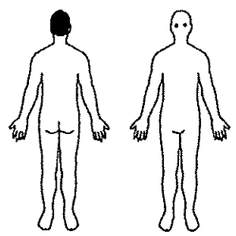
(WOMEN) Is there any chance that you are pregnant? ❑ Yes ❑ No

LOCATION AND TYPE OF PAIN (WHERE DOES IT HURT?)

PAIN DRAWING

Please indicate the appropriate location of pain and the symbol that best describes the discomfort you are presently experiencing.

Pain	=++++
Dull and Achy	=VVVV
Pins and Needles	=OOOO
Numbness	=////



Where does it hurt? (Neck pain, back pain, headache, etc.) _____

_____

_____

Have you had this type of pain in the past? _____

_____

_____

Are you on ❑ A blood thinner ❑ Aspirin ❑ Advil, etc. ❑ Antacid
❑ Laxatives ❑ Vitamins ❑ Herbal meds

BEFORE THE INJURY, did you have any of the following conditions?

GENERAL

❑ chronic fatigue
❑ weight loss (amount? _____, since when? _____)
❑ fever (recently)
❑ anemia
❑ bruise easily/bleed too long
❑ cancer (what type? _____)
❑ diabetes (when diagnosed? _____)
❑ thyroid disease
❑ nervousness
❑ allergies
❑ NO COMPLAINTS

EARS, EYES, NOSE & THROAT

❑ hoarseness ❑ dizzy spells ❑ recent vision changes ❑ NO COMPLAINTS

LUNGS

❑ asthma ❑ cough ❑ shortness of breath ❑ NO COMPLAINTS

HEART

❑ chest pain ❑ palpitations ❑ high blood pressure ❑ ankle swelling ❑ irregular heart beat
❑ phlebitis (blood clots) ❑ NO COMPLAINTS

NEUROLOGIC/PSYCHIATRIC

❑ stroke ❑ depression ❑ tremors/hands shaking ❑ numbness or tingling (where? _____)
❑ panic attacks ❑ migraines ❑ anxiety ❑ seizures ❑ memory loss ❑ NO COMPLAINTS

SKIN (skin/allergic immunology)

❑ rashes ❑ hives ❑ allergic reactions ❑ NO COMPLAINTS

GASTROINTESTINAL

❑ constipation ❑ stomach cramps ❑ nausea ❑ vomiting ❑ blood in the stool ❑ gas
❑ liver disease ❑ trouble swallowing ❑ NO COMPLAINTS

URINARY

❑ kidney stones ❑ decrease in urine force or flow ❑ NO COMPLAINTS

BONES & JOINTS

❑ arthritis/rheumatism ❑ gout ❑ back pain (chronic/recurrent) ❑ osteoporosis
❑ NO COMPLAINTS

AFTER THE INJURY, did you have any of the conditions listed above? ❑ Yes ❑ No

If yes, which one(s)? _____

NEW
HAVEN
CHIROPRACTIC
GROUP

DR. JAMES CIANCIOLO **DR. SARAH LEVIN**

1. I hereby authorize New Haven Chiropractic Group to receive any information which may have been acquired by examination or other means of my physical condition, and hereby release them of any consequences thereof.

2. I acknowledge that I have received and or read the privacy statement acknowledgement of the New Haven Chiropractic Group.

3. I hereby authorize release of information necessary to file a claim with my insurance company.

5. Patient is responsible for any outstanding balances due to the New Haven Chiropractic Group.

6. I assign benefits otherwise payable to me to the New Haven Chiropractic Group.

Date: _____/_____/_____ _____ PATIENT PRINT _____ PATIENT SIGNATURE

p 203.787.1331 f 203.787.1595
951 STATE STREET NEW HAVEN, CT 06511

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At New Haven Chiropractic Group maintaining our patients' trust and confidence is very important to us. That is why we have made it our priority to keep the imfortamtion you provide us safe and confidential. Our employees are educated on the importance of maintaining the confidentiality of your health information. The Practice's Privacy Notice has been provided to me prior to my signing this form. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out health care operations. The Practice explained to me that the Privacy Notice is available to me now, or in the future at my request.

The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law. I understand that, and consent to, the following appointment reminders that may be used by the Practice: a postcard mailed to me at the address provided by me; telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

The Practice may use and/or disclose my PHI (which includes information about my health or condition and treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations. I understand that I have a right to request an accounting of the disclosure of my PHI other than for treatment, payment and/or health care operations. I understand I may restrict access or disclosure of my PHI. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to be requested restriction, then the restriction is binding on the Practice. I understand the Practice may share my PHI with the Connecticut Chiropractic Association in the event advocacy is needed for insurance claims or utilization disputes. I acknowledge that I have received the Privacy Statement of the New Haven Chiropractic Group.

_____ _____

Name of Individual (Printed) Signature of Individual

_____ _____

Signature of Legal Representative Relationship
(e.g., Attorney-In-Fact, Guardian, Parent if a minor)

Date: _____/_____/_____ _____

Witness

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Informed Consent to Chiropractic Treatment

While rare, some patients may experience short term aggravation of symptoms, rib fractures, muscle and ligament strains/sprains, and dizziness as a result of manual therapy techniques. There are reported cases of stroke associate with many common neck movements including adjustment of the upper cervical spine. The apparent association is noted infrequently, however, you are being warned of this possible association because stroke can cause serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is rare, however, possible. There are rare reported cases of disc injuries following cervical and lumbar spinal adjustments or chiropractic treatment. Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Patient Name _____ **Date:** _____/_____/_____

Witness Name _____ **Date:** _____/_____/_____

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