Rotella Chiropractic & Acupuncture Center

**Patient Information**

*Thank you for choosing our practice for your Chiropractic, Acupuncture, herbal and nutritional needs. Please complete this form. Please note that information provided on this form is confidential. It is very important the information given are complete and accurate to assist you properly in your healing process. If you have any questions or concerns, do not hesitate to ask for assistance.*

(Please Print)

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_

First MI Last

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_

Sex: \_\_Female \_\_Male \_\_\_Transgender/Intersex \_\_Other

Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you prefer to receive calls at: \_\_Home \_\_Work \_\_\_ Cell \_\_\_Doesn’t matter

Is it ok to leave a message? \_\_\_\_\_yes \_\_\_\_no

Email address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it ok to send newsletter via email \_\_\_\_\_ Is it ok to send appointment reminders \_\_\_\_\_\_\_

Are you: \_\_Minor \_\_Married \_\_Divorced \_\_Widowed \_\_Single \_\_Separated \_\_\_Partnered

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For minor’s only - parent’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Condition**

Reason for visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did you first notice the symptoms?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this condition getting progressively worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where is the problem located?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



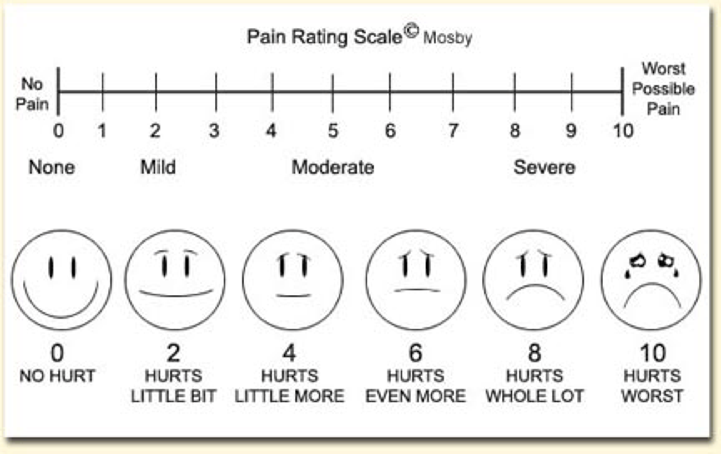
Please list all medications, vitamins and herbs you are currently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any of the following? **Cold sores, ringworm, bed bugs, open wounds, scabies, boils, fungal infections, lice, mites, warts, impetigo, erysipelas, shingles, HIV, Hepatitis, poison ivy, or any contagious conditions?**  Yes\_\_\_ No\_\_\_\_ If yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mark the diagram with pain and type of pain:

A – ACHE B – BURNING N – NUMBNESS P – PINS & NEEDLES S – STABBING O – OTHER.



**Rate the severity of your pain from 0 to 10**

Please mark any of the following conditions or symptoms that you currently have:

Other Symptoms:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Headaches \_\_ Pain in Hands or Arms \_\_ Chest Pains

\_\_ Neck Pain \_\_ Numbness in Hands or Arms \_\_ Heart Attack

\_\_ Sleeping Problems \_\_ Pain in Legs or Feet \_\_ High Blood Pressure

\_\_ Low Back Pain \_\_ Numbness in Legs or Feet \_\_ Stroke

\_\_ Nervousness \_\_ Fatigue \_\_ Cancer

\_\_ Tension \_\_ Depression \_\_ Painful Urination

\_\_ Irritability \_\_ Lights Bother Eyes \_\_ Diabetes

\_\_ Dizziness \_\_ Loss of Memory \_\_ Diarrhea

\_\_ Pain Between Shoulders \_\_ Shoulder Pain \_\_ Constipation

\_\_ Neck Stiff \_\_ Sinus \_\_ Stomach Upset

\_\_ Joint Swelling \_\_ Shortness of Breath \_\_ Heartburn/Reflux

\_\_ Fever \_\_ Asthma \_\_ Weight Loss

\_\_ Loss of Balance \_\_ Allergies \_\_ Loss of Smell or Taste

\_\_ Ringing in Ears \_\_ Cold Hands \_\_ Menstrual Cramps

\_\_ Jaw/TMJ Problems \_\_ Cold Feet \_\_ Menopause

Please describe your history of conditions (such as Cardiac problems, Cancer, etc..) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last physical exam \_\_\_\_\_\_\_\_\_

Are you pregnant (Y/N Taking Birth control pills Y/N

**Cancelation policy**

*We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment book.*

*Patient, who fail to show for their scheduled appointment, or did not notify the office within 48 hours of their scheduled appointment time, shall be subject to a “No Show/Cancellation” fee of $50. Individual circumstances may be given exception.*

**Authorization**

*I certify that I have read and understand the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous. I agree to be responsible for payment of all services rendered on my behalf or that of my dependents. I will be responsible for any outstanding sums due to this office, including interest, penalties, cancellation fees, return check fees, and all collection fees. I am aware that I will be responsible for additional fees for returned checks and that these fees may be directly withdrawn from my account.*

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient (or parent if a minor) Date