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?____

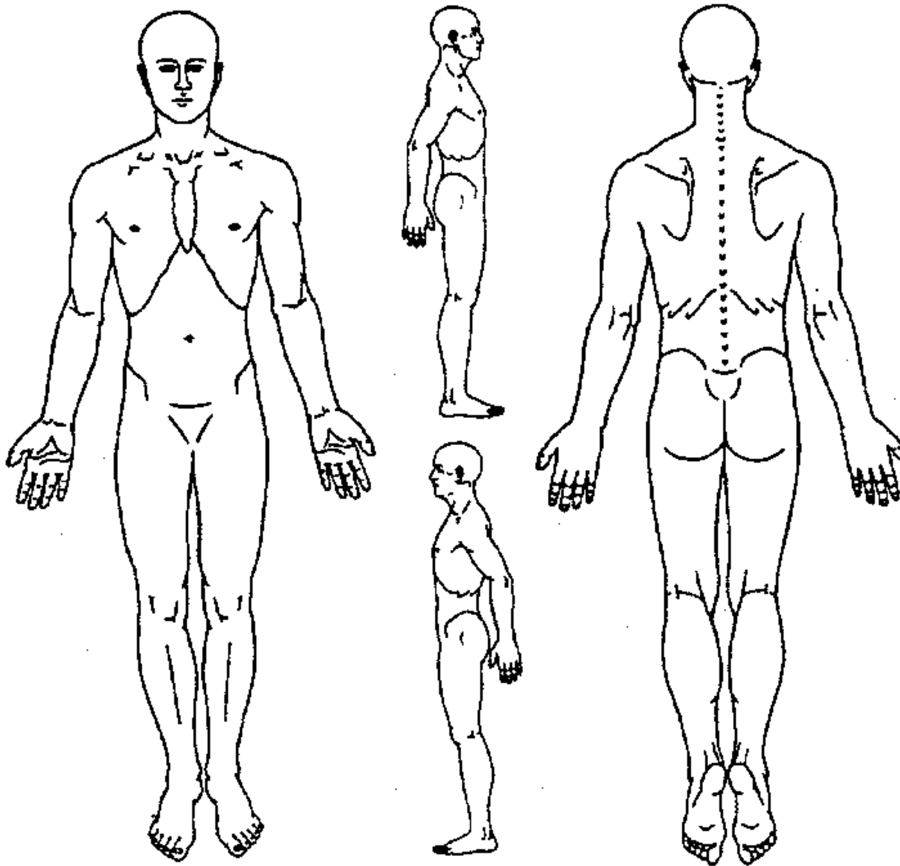
Please list all medications, vitamins and herbs you are currently taking:
____
____

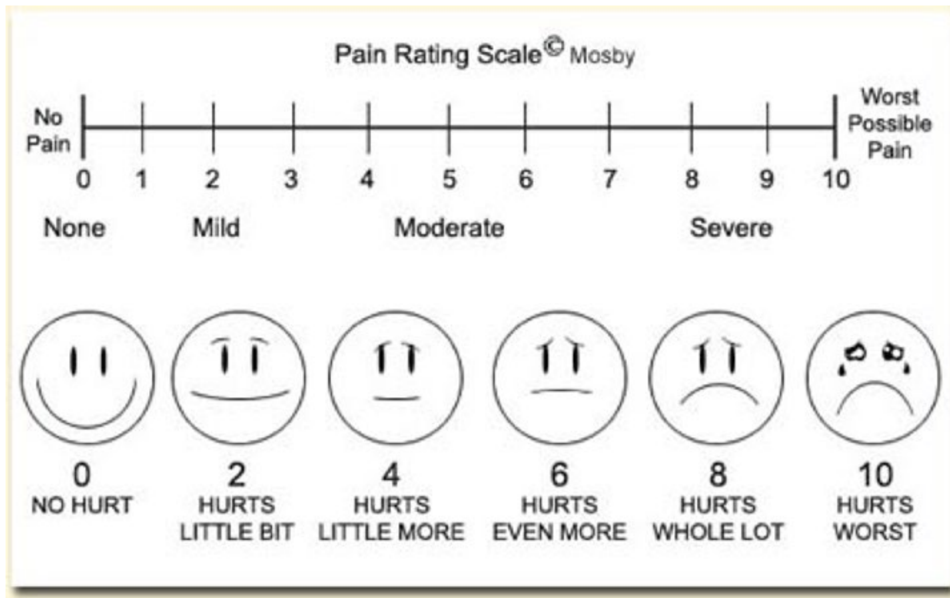
Allergies: ____

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..)

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Date of last physical exam _________________

Are you pregnant: Yes No Taking Birth control pills Yes No

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 <u>48 hours</u> 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