

PATIENT INFORMATION

Date: _____

Please print all information as clearly as possible. Please fill out form completely, all information is necessary to complete file and send claims on your behalf.

First Name (**no nicknames**) _____ M.I. _____ Last Name _____

Sex: M F Birthdate ____/____/____ Age _____ Social Security (required) ____/____/____

Marital Status: S M D/S W Spouse's Name _____

Permanent Mailing

Address: _____ City: _____ State: _____ Zip: _____

Temporary Mailing

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: () _____ - _____ Work Phone: () _____ - _____ Cell Phone: () _____ - _____

If you would like text message appt reminders, please tell us your mobile provider: _____

Employment Status: Full Time ___ Part Time ___ Student ___ Homemaker ___ Unemployed ___ Retired ___

Employer (required) _____ Type Of Work _____

Family Doctor: _____ Would you like us to send a Report to your Dr.? _____

Emergency Contact: Name: _____ Phone: () _____ - _____

Relationship: Spouse Parent Child Other

E-Mail Address: _____

How were you referred to our office?

TV _____ Newspaper _____ Internet _____ Radio _____ Yellow Pages _____ Direct Mail _____

Doctor ___ Friend ___ Relative ___ Name: _____

Primary Insurance

Insurance Company Full Name: _____

Policy ID #: _____ Group #: _____

Relationship to Insured: ___ Self ___ Spouse ___ Child/Step ___ Child ___ Parent ___ Other

Insured's First Name : _____ M.I.: _____ Last: _____

Insured's Address: _____ City: _____ State: _____ Zip: _____

Insured's Birthdate: ____/____/____ Insured's Social Security # (required): _____ - _____ - _____

Insured's Employer: _____ Work Phone: () _____ - _____ - _____

Secondary Insurance

Insurance Company Full Name: _____

Policy ID #: _____ Group #: _____

Relationship to Insured: Spouse ___ Child/Step Child ___ Parent ___ Other _____

Insured's First Name: _____ M.I.: _____ Last: _____

Insured's Address: _____ City: _____ State: _____ Zip: _____

Insured's Birthdate: ____/____/____ Insured's Social Security # (required): _____ - _____ - _____

Insured's Employer: _____ Work Phone: () _____ - _____ - _____

Cause Of Complaint: Auto Accident ___ Work Injury ___ Other Accident ___ Illness ___ Congenital ___ Unknown

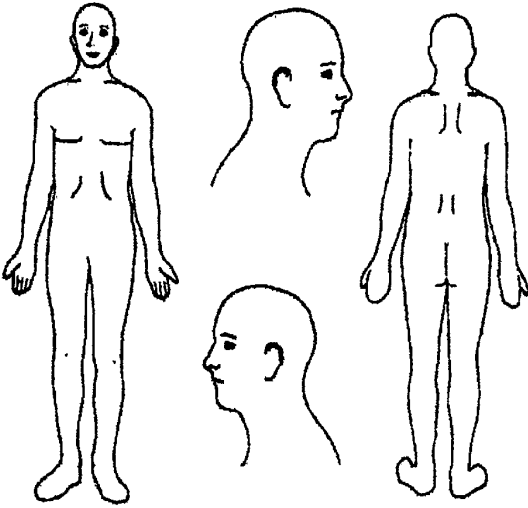
If Accident: * Attorney Name: _____ Phone: () _____ - _____

**OLIVIERI CHIROPRACTIC & REHABILITATION CENTER
PRESENT HEALTH HISTORY**

Name: _____ Date: _____

PLEASE SHADE ALL AREAS OF PAIN:

Please check ALL that describe your symptoms:



- | | | |
|------------------------------------|------------------------------------|---|
| <input type="checkbox"/> DULL | <input type="checkbox"/> STABBING | <input type="checkbox"/> PINS & NEEDLES |
| <input type="checkbox"/> SHARP | <input type="checkbox"/> TIGHTNESS | <input type="checkbox"/> NUMBNESS |
| <input type="checkbox"/> THROBBING | <input type="checkbox"/> CRAMPING | <input type="checkbox"/> ACHING |
| <input type="checkbox"/> BURNING | <input type="checkbox"/> WEAKNESS | |

**Check ALL that describe your symptoms and indicate the area of pain:
And Rate your Pain level from 1-10 next to your symptoms**

- | | |
|---|--|
| <input type="checkbox"/> R L Headaches _____ | <input type="checkbox"/> R L Groin Pain _____ |
| <input type="checkbox"/> R L Neck Pain _____ | <input type="checkbox"/> R L Hip Pain _____ |
| <input type="checkbox"/> R L Radiating into:
Arm, Forearm, Hand _____ | <input type="checkbox"/> R L Thigh Pain _____ |
| <input type="checkbox"/> R L Upper Back Pain _____ | <input type="checkbox"/> R L Knee Pain _____ |
| <input type="checkbox"/> R L Mid Back Pain _____ | <input type="checkbox"/> R L Calf Pain _____ |
| <input type="checkbox"/> R L Under Shoulder Blade _____ | <input type="checkbox"/> R L Ankle Pain _____ |
| <input type="checkbox"/> R L Chest Pain _____ | <input type="checkbox"/> R L Foot Pain _____ |
| <input type="checkbox"/> R L Low Back Pain _____ | <input type="checkbox"/> R L Shoulder Pain _____ |
| <input type="checkbox"/> R L Sciatica, radiating into:
Leg, Calf, Foot _____ | <input type="checkbox"/> R L Elbow Pain _____ |
| <input type="checkbox"/> R L Buttock Pain _____ | <input type="checkbox"/> R L Wrist Pain _____ |
| | <input type="checkbox"/> R L Hand Pain _____ |
| | <input type="checkbox"/> R L Dizziness _____ |

When did your present condition begin? Please provide an approximate date: _____

What happened to cause your present symptoms? _____

What makes your pain better?

- | | | | | | |
|-----------------------------------|--------------------------------------|------------------------------------|-------------------------------------|---|--|
| <input type="checkbox"/> Rest | <input type="checkbox"/> Heating Pad | <input type="checkbox"/> BioFreeze | <input type="checkbox"/> Massage | <input type="checkbox"/> Cervical Pillow | <input type="checkbox"/> Prescription Medication |
| <input type="checkbox"/> Ice Pack | <input type="checkbox"/> Stretching | <input type="checkbox"/> Exercise | <input type="checkbox"/> Back Brace | <input type="checkbox"/> Changing Positions | <input type="checkbox"/> Drug Store Medication |

What makes your pain worse?

- | | | | | | |
|-----------------------------------|----------------------------------|-----------------------------------|------------------------------------|--|---|
| <input type="checkbox"/> Bending | <input type="checkbox"/> Lifting | <input type="checkbox"/> Pulling | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Heating Pad | <input type="checkbox"/> Prolonged Sitting |
| <input type="checkbox"/> Twisting | <input type="checkbox"/> Pushing | <input type="checkbox"/> Coughing | <input type="checkbox"/> Ice Packs | <input type="checkbox"/> Prolonged Walking | <input type="checkbox"/> Prolonged Standing |

What home remedies have you tried?

- | | | | | | | |
|-----------------------------------|--------------------------------------|-----------------------------------|-----------------------------------|----------------------------------|----------------------------------|-------------------------------------|
| <input type="checkbox"/> Ice Pack | <input type="checkbox"/> Heating Pad | <input type="checkbox"/> Exercise | <input type="checkbox"/> Bed Rest | <input type="checkbox"/> Massage | <input type="checkbox"/> Hot Tub | <input type="checkbox"/> Medication |
|-----------------------------------|--------------------------------------|-----------------------------------|-----------------------------------|----------------------------------|----------------------------------|-------------------------------------|

Are you presently taking any medication? YES NO Please list all: _____

Have you seen any other doctor(s) for this condition? YES NO Doctor(s): _____

Did the doctor(s) recommend any treatment, order any tests, or prescribe any medication? YES NO

Please list treatments/tests/medications: _____ **Did it help?** YES NO

Have you ever had these symptoms before? YES NO Date: _____ Cause: _____ Treatment: _____

Have you missed any work from this condition? YES NO Dates: From: _____ To: _____ **Currently out of work?** YES NO

Have you ever lost any bowel or bladder control? YES NO

Have you experienced pain at night that awakes you from a sound sleep? YES NO

Have you had any sudden unexplained weight loss or gain within the last 6 months? (greater than 10 lbs) YES NO

Have you had a change in the taste or smell of food? YES NO

Does coughing or sneezing increase your pain? YES NO

Have you noticed any unusual lumps, bumps, or bleeding recently? YES NO

PAST MEDICAL HISTORY

Name: _____ Date: _____

Have you ever had any previous *Hospitalizations or Surgeries*? YES NO

Please list all past hospitalizations and/or surgeries with their approximate date.

Have you ever has previous *Past Physical Trauma or Injuries*? YES NO

Please list all previous injuries sustained during automobile, sports, slip and falls, and/or work related activities and the approximate date of injury. Indicate whether you are still being treated for any condition associated with these past physical traumas. _____

FAMILY MEDICAL HISTORY

Indicate with a checkmark if you know of any blood relative who has or had any of the following conditions.

- | | | |
|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Seizures | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Headaches | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Psychiatric Disease |
| <input type="checkbox"/> Brain Tumor | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer, Type _____ | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung Disease | |

Comments: _____

VITAMINS / HOW MUCH / BRAND

Please list all vitamins/herbs/supplements that you are currently taking. Also, list how much of each supplement you are taking.

<u>TYPE</u>	<u>HOW MUCH</u>	<u>BRAND</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST MEDICAL HISTORY

Please check all boxes for those condition(s) that are part of your medical history. If you are unsure if one applies to you or you do not understand a term, do not check the box. Please take your time.....

- 090 General Good Health
091 Desires Nutritional & Metabolic Analysis
001 Skin Disorder 692.9
002 Acne 706.1
003 Psoriasis 696.1
004 Urticaria (Hives) 708.9
005 ADD/ADHD 314.00/314.01
006 Allergies, Unspecified 477.9
007 Allergic Rhinitis from food 477.1
008 Sinusitis 461.9
009 Alzheimer's 331.0
010 Poor Concentration/Memory 310.1
011 Parkinson's Disease 332.0
012 Anemia 285.9
013 Arthritic Disorder 716.90
014 Osteoporosis 733.00
015 Asthma 493.90
016 Emphysema 492.8
017 Cancer
 018 Breast 174.9female 175.9male
 019 Prostate 185
 020 Lung 162.9
 021 Colon and Rectal 153.9
 022 Skin 173.9
 023 Leukemia w/o remission 208.90
 Leukemia w/ remission 208.91
 024 Lymphoma, malignant 202.8
 025 Brain Tumor, malignant 191.9
027 Anxiety Disorder 300.00
028 Autism 299.00
033 Edema 782.3
034 Eczema 692.9
035 Chronic Fatigue 780.71
036 Circulatory Disorder 459.9
037 Heart Disease 429.9
038 High Cholesterol 272.0
039 High Blood Pressure 401.9
040 Low Blood Pressure 458.9
041 Tachycardia
 (High Heart Rate) 785.00
042 Numbness 782.0
043 Constipation 564.0
044 Indigestion 536.8
045 Ulcerative Colitis 556.9
046 Depression 311
047 Diabetes Mellitus 250.0
030 Diabetes Type I 250.01
031 Diabetes Type II 250.02
029 Hyperglycemia
 [high blood sugar] 790.29
048 Hypoglycemia
 [low blood sugar] 251.2
049 Dizziness/Balance Problem 780.4
050 Ear Infection 381.4
051 Epstein Barr 075
052 Eye Problems 379.91
053 Cataracts 366.9
054 Glaucoma 365.9
055 Macular Degeneration 362.50
056 Fever 780.6
057 Fibromyalgia 729.1
058 Gallbladder Disorder 575.9
059 Gout 274.9
060 Headaches 784.0
061 Hearing Loss 389.9
062 Infertility, male 606.9
064 Liver Disease 571.9
 065 Hepatitis 573.3
 066 Hepatitis B 070.30
 067 Hepatitis C 070.51
068 Kidney Disorder 593.9 or Bladder Disorder 596.9
063 Prostate Disorder 602.9
069 Hyperthyroidism 242.90
070 Hypothyroidism 244.9
071 Systemic Lupus 710.0
072 Infertility, female 628.9
073 Interstitial Cystitis 595.1
074 Irregular Menstrual Cycle 626.4
075 Menopausal Symptoms 627.2
076 Hot Flashes 627.2
077 Mental Disorder 300.9
078 Insomnia 780.52
079 Mouth/Throat/Tongue
080 Canker Sores 528.2
081 Overweight 278.02
082 Underweight 783.22
083 Sexual Disorder 302.89
084 Spinal Problems 724.9
085 Obesity 278.00
086 GERD 530.81
087 HIV 042
088 Crohn's Disease 555.9
089 Irritable Bowel Syndrome 564.1
092 Normal Pregnancy v22.2
 **only applicable if *currently* pregnant
093 Shingles 053.9
140 Migraines 346.90
141 Rheumatoid Arthritis 714.0
142 Non-Systemic Lupus 695.4
143 Multiple Sclerosis 340
144 ALS (Lou Gerigs) 335.20
145 Polymyalgia Rheumatica 725
146 Scleroderma 710.1
171 Goiter 240.9
178 Raynaud's Syndrome 443.8
179 Hemochromatosis 275.0
180 Thalassemia 282.49
181 Brain aneurysm 431

General Health

- 100 Fingernail base is pink
101 Fingernail base is purple
102 Fingernails have ridges or white spots
103 Fingernails are soft
104 Fingernails are splitting
105 Fingernails peel
106 Pale fingernail beds
107 Blacks out easily
108 Balance problems
109 Difficulty walking
110 Has tattoos
111 Brittle hair
112 Dry hair
113 Thin hair
114 Hair loss
115 Drinks alcoholic beverages daily
116 Drinks less than 8 glasses of water per day
117 Currently on Chemotherapy
118 Currently on radiation treatment
148 Had radiation therapy in the last year
149 Had chemotherapy in the last year
119 Had chemotherapy in the past
120 Has had radiation treatments in the past
121 Gained over 20 lbs in the last 12 months
122 Somewhat Overweight
123 Somewhat Underweight
- 124 Unexplained weight loss of over 20lbs within the last 4 months
125 Energy level is worse than it was 5 years ago
127 Sleeps less than 6 hours per night
128 Unable to recall dreams the next day
129 Sensitive to chemicals, paint, fumes, cologne
130 Had blood transfusion in the past
131 Had transplant in the past
138 Takes anti-rejection drugs
132 Had a major accident or injury
137 Sleep Apnea
139 Toxic chemical exposure
175 Has been out of the country recently
176 Had childhood vaccines
177 Had a vaccine in the last 12 months
147 Had a flu shot last year
182 Had a pneumonia vaccine last year
183 Had a Hepatitis B vaccine in the last 2 years.
- Has a family history of:
- 184 Cancer
185 Heart Disease
186 Diabetes
187 Alcoholism
188 Depression
189 Obesity

Social History

- 380 Drinks beverages from a can
370 Drinks alcohol
371 Drinks caffeinated coffee
372 Drinks caffeinated pop/soda
373 Drinks caffeinated tea
374 Drinks decaffeinated coffee
375 Drinks decaffeinated pop/soda
376 Drinks decaffeinated tea
377 Drinks more than 3 cups of coffee per day
378 Drinks more than 3 cups of tea per day
388 Drinks diet pop/soda
- 379 Drinks 1 or more pop/sodas per day
I had 4 alcoholic drinks in one day:
172 never
173 more than 3 months ago
174 less than 3 months ago
381 Has more than 5 alcoholic drinks per week
391 Craves sugar / starches
382 Currently smokes
383 Quit smoking in the last 5 years
384 Smoked for more than 5 years
- 385 Smokes more than 1 pack per day
126 Rarely exercises
133 Regularly exercises
386 Takes Vitamins
134 Vegetarian
135 Eats no red meat
136 Eats no meat, no dairy
387 Frequent use of artificial sweeteners
389 Anorexia
390 Bulimic

Surgeries

- 700 Tonsillectomy and/or Adenoids
701 Appendix
702 Gallbladder
703 Thyroid
715 Radiated thyroid
708 Cancer
- 704 Hysterectomy, complete
705 Hysterectomy, partial
706 Tubal ligation
707 Breast implants
709 Coronary by-pass
710 Spinal surgery
- 711 Extremity surgery
712 Hip replacement
713 Knee replacement
714 Splenectomy
716 Cataract surgery
717 Hemorrhoidectomy

Gastrointestinal

- 265 4-5 bowel movements per week
- 266 3 or less bowel movements per week
- 267 6 or more bowel movements per week
- 268 Black tarry stools
- 269 Pale or yellow colored stool
- 270 Blood stools
- 271 Constipation
- 272 Hemorrhoids
- 273 Loose bowel movements
- 274 Frequent diarrhea
- 275 Frequent nausea
- 276 Frequent vomiting
- 277 Abdominal gas
- 278 Belching and burping after eating
- 279 Bloating after eating
- 280 Severe abdominal pains
- 281 Stomach ulcers
- 282 Uses digestive aids
- 283 Uses laxatives
- 284 Immediate indigestion upon eating
- 285 Indigestion in 2 hours or more after meals
- 286 Indigestion within 1 hour after meals
- 287 Difficulty swallowing
- 288 Eating relieves fatigue
- 289 Eats when nervous
- 290 Excessive hunger
- 291 Poor appetite
- 292 Experiences fainting spells when hungry
- 293 Feels shaky when hungry
- 294 Frequently drowsy after eating a meal
- 295 Gall bladder disease
- 296 Has had intestinal worms
- 297 Reflux/Hiatal hernia
- 298 Liver disease
- 299 Irritable Bowel Syndrome
- 300 Diverticulitis
- 301 Diverticulosis

Respiratory

- 485 Catches severe colds
- 487 Chronic cough
- 488 Constant runny nose
- 489 COPD
- 490 Difficulty breathing
- 491 Frequent colds
- 492 Frequent nose bleeds
- 493 Frequent sinus infections
- 494 Frequent stuffy nose
- 495 Hay fever
- 496 Nasal polyps
- 497 Night sweats
- 498 Post nasal drip
- 499 Sneezing spells
- 500 Spits up blood
- 501 Spits up phlegm
- 502 Wheezes

Mouth and Throat

- 400 Bad breath
- 401 Bitter taste in the mouth in the morning
- 402 Dry mouth
- 403 Excessive saliva
- 404 Sores or cracks in the corners of the mouth
- 405 Glands often swell
- 406 Frequent canker sores
- 407 Frequent fever blisters
- 408 Frequent sore throats
- 409 Frequently has a sore tongue
- 410 Sore gums
- 411 Swollen gums
- 412 Swollen tongue
- 413 Tongue burns
- 414 Tongue has grooves or fissures
- 415 Tongue is coated
- 416 Gums bleed when brushing teeth
- 417 Toothaches
- 418 Amalgam dental fillings
- 420 Other dental fillings (gold, composite, etc)
- 419 Has had root canal(s)

Endocrine

- 245 Coarse hair
- 246 Coarse skin
- 247 Diabetic
- 248 Excessive thirst
- 249 Frequently feels cold
- 250 Frequently feels hot
- 251 Gets lightheaded when standing quickly
- 252 Heals slowly
- 253 Unusually jumpy or nervous
- 254 Unusually tired most of the time

Cardiovascular

- 190 Cold feet
- 191 Cold hands
- 192 Experiences shortness of breath while sitting still
- 193 Heart skips beats
- 194 Tendency of High blood pressure
- 195 Leg cramps during bedtime
- 196 Leg cramps during daytime
- 197 Low blood pressure at times
- 198 Pain in leg/hips when walking
- 199 Frequent swollen ankles
- 200 Pains in the heart or chest
- 201 Spells of rapid heart rate
- 202 Troubled with blood clots
- 203 Unusually slow pulse rate
- 204 Varicose veins
- 205 Heart palpitations

Skin

- 520 Bruises easily
- 521 Excessive perspiration
- 522 Frequent goose bumps
- 523 Has acne
- 524 Has Psoriasis
- 525 Hives
- 526 Itchy skin
- 527 Problems with Eczema
- 528 Has moles which are changing in size and/or color
- 530 Skin is rough, especially on the back of the arms
- 529 Skin eruptions
- 531 Skin is tender
- 532 Sores that heal slowly
- 533 Troubled with boils
- 534 Dry skin

Ears

- 220 Discharge from ears
- 221 Hard of hearing
- 222 Punctured ear drum
- 223 Recurrent ear infection
- 224 Ringing or noises in the ears
- 225 Tinnitus

Eyes

- 320 Bloodshot eyes
- 321 Blurred vision
- 322 Cross eyes
- 323 Eye pain
- 324 Eyes feel gritty
- 325 Eyes watery
- 326 Mild Glaucoma
- 327 Far sighted
- 328 Developing cataracts
- 329 Mild Macular degeneration
- 330 Itchy eyes
- 331 Near sighted
- 332 Dry Eyes

Feet

- 350 Corns
- 351 Frequent foot cramps
- 352 Heel spurs
- 353 Painful feet
- 354 Plantar warts
- 355 Swelling in the feet and/or ankles
- 356 Plantar fasciitis
- 357 Fungal Infection

Neuromuscular

- 440 Bites nails
- 441 Frequent muscle soreness
- 442 Muscle spasms
- 443 Muscle weakness
- 444 Tremors
- 445 Frequent headaches
- 446 Often dizzy
- 447 Frequently feels faint
- 448 Has Epilepsy
- 449 Has motion sickness
- 450 Has Osteoarthritis
- 451 Has Rheumatism
- 452 Rheumatoid Arthritis
- 453 Joint stiffness in the morning
- 454 Swollen joints
- 455 Leg pain at rest
- 456 Spinal curvature
- 457 Low back pain
- 458 Neck pain
- 459 Pain between the shoulders
- 460 Shoulder/arm pain
- 461 Numbness/tingling in the body
- 462 Sleep walks
- 463 Stutters or stammers
- 464 Nerve pain

Behavior Patterns

- 150 Afraid to eat anywhere except home
- 151 Always needs someone to advise
- 152 Cries often
- 153 Difficulty concentrating
- 154 Difficulty falling asleep
- 155 Difficulty staying asleep
- 156 Easily angered
- 157 Feelings are easily hurt
- 158 Frequently becomes scared for no reason
- 159 Frequently miserable or blue
- 160 Has to be on guard even with friends
- 161 Often annoyed by people
- 162 Recurrent bad dreams
- 163 Sometimes wishes to be dead or away from it all
- 164 Upset by criticism
- 165 Poor memory
- 166 Scared to be alone
- 167 Strange people or places cause fear
- 168 Under considerable emotional stress
- 169 Unhappy when other are happy
- 170 Brain fog

Urinary

- 556 Bed wetting
- 557 Blood in the urine
- 558 Difficulty starting urination
- 559 Painful urination
- 560 Frequent urination
- 561 Troubled by urgent urination
- 562 Incontinence when sneezing or laughing
- 563 Loses bladder control
- 564 Frequent bladder infections
- 565 Frequent kidney infections
- 566 Kidney stones

Men Only

- 585 Difficulty completing intercourse
- 586 Difficulty getting or keeping an erection
- 587 Discharge from the urethra
- 588 Had a vasectomy
- 589 Had difficulty fathering children
- 590 Lumps in the testicles
- 591 Painful genitals
- 592 Prostate troubles
- 593 Sores on external genitalia
- 594 Herpes
- 595 Sexual diseases

Women Only

- 610 Heavy hair growth on face or body
- 611 Cycles are every 27-29 days
- 612 Abnormal cycle >29 days and/or <26 days
- 613 PMS
- 614 Menstrual cramps
- 615 Painful periods
- 616 Acne worse at menstruation
- 617 Excessive menstrual flow
- 618 Retains fluid during periods
- 619 Pre-menstrual depression
- 620 Currently taking birth control medication
- 621 Has taken birth control medication more than 1 year
- 622 Has taken birth control medication within the last year
- 623 Has had miscarriage
- 624 Hot flashes
- 625 Takes hormone replacement medication
- 627 Diminished sexual desire
- 628 Painful intercourse
- 629 Poor or infrequent orgasm
- 630 Lumps in the breasts
- 631 Tender breasts
- 633 Vaginal discharge
- 634 Bloody spotting discharge
- 635 Yeast infections
- 636 Sores on external genitalia
- 637 Herpes
- 638 Sexual diseases
- 639 Endometriosis
- 640 Breast reduction
- 641 Breast augmentation
- 642 Abortion
- 643 D&C
- 644 Tubal pregnancy
- 645 Uterine fibroids
- 646 Ovarian fibroids
- 647 Breast fibroids
- 648 Currently Breastfeeding

ACTIVITIES OF DAILY LIVING ASSESSMENT

Name: _____ Date: _____

Please circle the number which most closely describes your chief complaint(s) today:

1. Pain Intensity

----- (0) ----- (1) ----- (2) ----- (3) ----- (4) ----- (5) ----- (6) ----- (7) ----- (8) ----- (9) ----- (10) -----
 No Pain Worst Possible Pain

2. Frequency Of Pain

----- (0) ----- (1) ----- (2) ----- (3) ----- (4) -----
 No Pain Occasional Pain Intermittent Pain Frequent Pain Constant Pain
 25% Of The Day 50% Of The Day 75% Of The Day 100% Of The Day

3. Personal Care (Washing, Dressing, etc.)

----- (0) ----- (1) ----- (2) ----- (3) ----- (4) -----
 No Pain Mild Pain Moderate Pain Moderate Pain Severe Pain
 No Restrictions No Restrictions Need to go slowly Need some assistance Need 100% Assistance

4. Travel (Driving, Riding, etc.)

----- (0) ----- (1) ----- (2) ----- (3) ----- (4) -----
 No Pain Mild Pain Moderate Pain Moderate Pain Severe Pain
 On Long Trips On Long Trips On Long Trips On Short Trips On Short Trips

5. Work

----- (0) ----- (1) ----- (2) ----- (3) ----- (4) -----
 Can Do Usual Work Can Do Usual Work Can Do 50% Can Do 25% Cannot Work
 Plus Extra Work No Extra Work Of Usual Work Of Usual Work

6. Recreation

----- (0) ----- (1) ----- (2) ----- (3) ----- (4) -----
 Can Do All Can Do Most Can Do Some Can Do A Few Cannot Do Any
 Activities Activities Activities Activities Activities

7. Sleeping

----- (0) ----- (1) ----- (2) ----- (3) ----- (4) -----
 Perfect Mildly Moderately Greatly Totally
 Sleep Disturbed Disturbed Disturbed Disturbed

8. Lifting

----- (0) ----- (1) ----- (2) ----- (3) ----- (4) -----
 No Pain Increased Pain Increased Pain Increased Pain Increased Pain
 With Heavy Weight With Heavy Weight With Mod Weight With Light Weight With Any Weight

9. Walking

----- (0) ----- (1) ----- (2) ----- (3) ----- (4) -----
 No Pain Increased Pain Increased Pain Increased Pain Increased Pain
 Any distance After One Mile After Half Mile After Quarter Mile With All Walking

10. Standing

----- (0) ----- (1) ----- (2) ----- (3) ----- (4) -----
 No Pain Increased Pain Increased Pain Increased Pain Increased Pain
 After Several Hours After Several Hours After One Hour After Half Hour With Any Standing

What would you like to be able to do again that you presently cannot? _____

CIRCLE THE TYPE OF CARE YOU WOULD LIKE TO RECEIVE (YOU MAY CHOOSE MORE THAN ONE OPTION):

Acute Care Corrective Care Home Exercise Program In-Office Exercise Program Physical Therapy

OLIVIERI CHIROPRACTIC & REHABILITATION CENTER

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Olivieri Chiropractic and Rehabilitation Center is required by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (Example)

“On occasion, it may be necessary to seek consultation regarding your condition from other healthcare providers associated with Olivieri Chiropractic and Rehabilitation Center.”

“It is our policy to provide a substitute healthcare provider, authorized by Olivieri Chiropractic and Rehabilitation Center to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary healthcare provider’s absence due to vacation, sickness, or other emergency situation.”

Payment

We may disclose your health information to your insurance provider for the purpose of payment or healthcare operations. (Example)

“As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Olivieri Chiropractic and Rehabilitation Center for healthcare services rendered. If you pay for your healthcare services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the healthcare services received.”

Workers’ Compensation

We may disclose your health information as necessary to comply with State Workers’ Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceedings.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing

We may contact you for marketing purposes or fundraising purposes, as described below:
(Example)

“As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. “If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.”

“It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, postcard, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Olivieri Chiropractic and Rehabilitation Center sponsored fund-raising events.”

Change of Ownership

In the event that Olivieri Chiropractic and Rehabilitation Center is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Olivieri Chiropractic and Rehabilitation Center is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Olivieri Chiropractic and Rehabilitation Center amend your protected health information. Please be advised, however, that Olivieri Chiropractic and Rehabilitation Center is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Olivieri Chiropractic and Rehabilitation Center.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Olivieri Chiropractic and Rehabilitation Center reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Olivieri Chiropractic and Rehabilitation Center is required by law to comply with this Notice.

Olivieri Chiropractic and Rehabilitation Center is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact Ronald Glover by calling this office at 609-886-8585. If Ronald Glover is not available, you may make an appointment for a personal conference in person or by telephone within two (2) working days.

Complaints

Complaints about your Privacy Rights, or how Olivieri Chiropractic and Rehabilitation Center has handled your health information should be directed to Ronald Glover by calling this office at 609-886-8585. If Ronald Glover is not available, you may make an appointment for a personal conference in person or by telephone within two (2) working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, DC 20201

This notice is effective as of April 14, 2003.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Olivieri Chiropractic and Rehabilitation Center with my authorization and consent to use and disclose my protected healthcare information for the purposes of treatment, payment and healthcare operations as described in the Privacy Notice.

Patient's Name (print)

Patient's Signature

Date

Authorized Facility Signature

Date

OLIVIERI CHIROPRACTIC & REHABILITATION

Informed Consent for Chiropractic Care, Physical Therapy, Spinal Manipulation, Diagnostic X-Rays and Treatment, Authorization and Release.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic or physical therapy procedures, including various modes of therapy or modalities and diagnostic x-rays, on myself (or on the patient named below for whom I am legally responsible) by the licensed doctors of chiropractic of the Olivieri Chiropractic and Rehabilitation Center or any other doctor or physical therapist, who now or in the future, works in relief.

I have had the opportunity to discuss with my doctor the nature and purpose of chiropractic adjustments and other procedures and understand that spinal manipulation involves the doctor placing his or her hands on my spine and delivering a quick thrust or impulse to the involved area(s). I also understand and am informed that, as in the practice of medicine, in the practice of chiropractic and physical therapy, there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, soreness, and physical modality injuries and I am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I authorize payment of insurance benefits directly to Olivieri Chiropractic and Rehabilitation Center. I understand and agree to allow this office to use my Confidential Patient Health Information forms for the purpose of treatment, payment, healthcare operations, testimonial and coordination of care and authorize Olivieri Chiropractic and Rehabilitation Center to communicate with my medical physician(s) about my condition and treatment. I understand and agree that I am responsible for all cost of chiropractic care, regardless of insurance coverage. I also understand and agree that if I suspend or terminate my schedule of care as determined by my treating doctor or therapist, any fees for professional services will be immediately due and payable.

I am also aware that this office offers physical therapy services, provided by a licensed physical therapist. Patients that may benefit from this form of rehabilitation will be given the recommendation to seek these physical therapy services. I understand that I may seek these services at any facility I choose and I am under no obligation to have them performed here.

I have read the above information regarding consent, or it has been thoroughly explained to me. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients (for X-Ray purposes): By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

_____	_____	_____
(Print) Patient's Name	Patient's Signature	Date
_____	_____	_____
Relation/Authorized Person if Not Signed by Patient	Witness	

Consent to Treatment of Minor Child

I hereby authorize Dr. Robert Olivieri, Dr. Peter Olson, Ronald Glover, P.T. and whomever they may designate as an assistant to administer treatment as deemed necessary to my (son, daughter, step-son, step-daughter, other).

Child's Name _____ Guardian _____ Date _____

Motor Vehicle Accident Patients ONLY: Consent for Permanent Impairment Rating

By virtue of my signature on this form, I give my permission to any and all authorized representatives of this office known as Olivieri Chiropractic and Rehabilitation Center, to disclose and release in writing or any other format, the results of my permanent medical impairment evaluation. Furthermore, I have been informed of the medically rated permanent impairments and reduced functional capabilities that relate to my status. I have acknowledged and been made aware of any and all bodily losses, as well as future ramifications as they may apply to me.

_____	_____	_____
Patient Signature	Witness	Date