NEW PATIENT INTAKE FORM

Altorelli Chiropractic and Wellness
125 New Milford Turnpike, New Preston, CT 06777

PLEASE COMPLETE THE FOLLOWING INFORMATION. NOTE THAT ALL INFORMATION YOU PROVIDE WILL BE HELD IN STRICT CONFIDENCE AND WILL NOT BE DIVULDGED TO OTHERS WITHOUT YOUR AUTHORIZATION.

Personal Information

Today's Date:_____Last Name:_____First Name:_____MI:___

Address:_____City:_____State:____Zip:_____

Home Phone: (____)_____Work: (____)_____Cell: (____)_____

Do you wish to receive follow-up calls? Yes □ No □ Where? Home □ Work □ Cell □

E-Mail:_____Do you wish to receive a newsletter? Yes □ No □

DOB:____/____/_____Sex: Male □ Female □ Status: Married □ Single □ Other □

Driver's License Number:_____ State:_____

Primary Care Physician:_____City/State:_____Phone:_____

Occupation: _____FULL/PART TIME/RETIRED

Emergency Contact Info: Last Name:_____First Name:_____MI:____

Address:_____City:_____State:____Zip:_____

Relationship to patient:_____Cell Phone:_____

If the patient is under the age of 18: IF NOT, PLEASE SKIP THIS SECTION

Name of Mother_____Phone: (____)_____

Name of Father_____Phone: (____)_____

Legal Guardian:_____Relationship:_____Phone: (____)_____

MEDICARE? Yes □ No □ IF NO, PLEASE SKIP TO THE NEXT PAGE

MEDICARE ID Number:_____Effective Date:_____/_____/_____

Subscriber Last Name:_____First Name:_____MI:_____

Date of Birth:____/____/_____SSN: _____-_____-_____Gender: Male □ Female □

Address:_____City:_____State:____Zip:_____

Home Phone: (____)_____Relationship to patient:_____

PATIENT HEALTH QUESTIONNAIRE

Patient Name:_____**Date:**_____

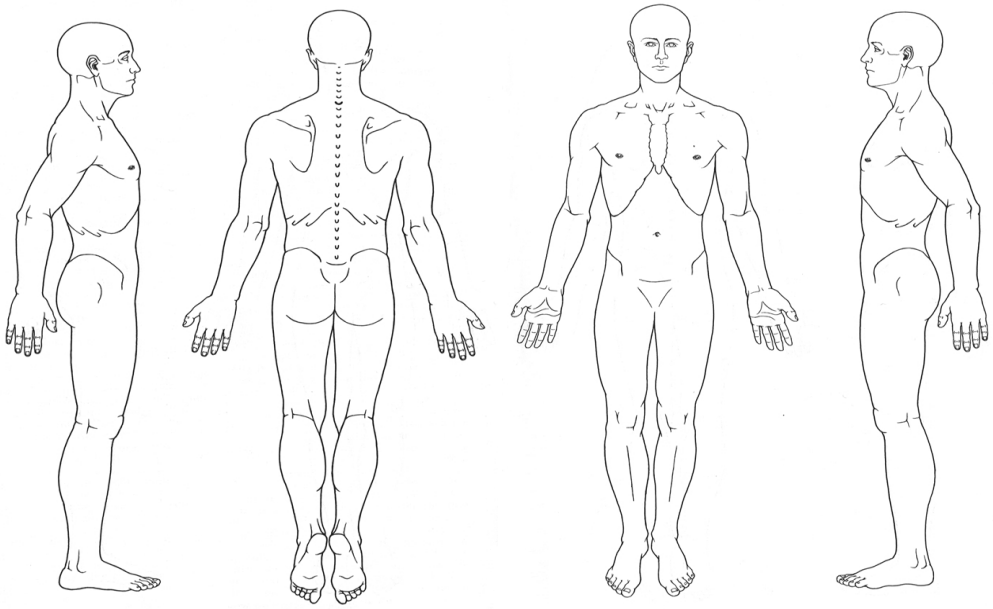
I AM CURRENTLY IN PAIN: Yes □ No □ IF NO, PLEASE SKIP TO THE NEXT PAGE

PAIN DRAWING AND SCALE: On a scale from 0-10, how do you rate your current pain?_____

Please mark the quality and location of your pain on the body outlines below.

Please use the code letters as indicated below:

A = Ache B = Burning N = Numbness P = Pins & Needles S = Stabbing X = Other



1. **When did your symptoms start?**_____
   Describe your symptoms and how they began: _____
   _____
2. **How often do you experience symptoms?**
   □ Constantly (76-100% of the day) □ Frequently (51-75% of the day)
   □ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)
3. **How are your symptoms changing?** □ Getting Better □ Not Changing □ Getting Worse
4. **How do your symptoms affect your ability to perform daily activities?**

⓿	①	②	③	④	⑤	⑥	⑦	⑧	⑨	❿
No complaints		Mild, forgotten with activity		Moderate, interferes with activity		Limiting, prevents full activity		Intense, preoccupied with seeking relief		Severe

5. **What activities make your symptoms worse?** _____
6. **What activities make your symptoms better?** _____
7. **Who have you seen for your symptoms?** _____
   a. **When and what treatment?**_____
   b. **What tests were performed?**_____**Date Taken:**_____
8. **Have you had similar symptoms in the past? ……Yes □ No □**
9. **Is this condition or problem caused by an auto accident? ……Yes □ No □**
10. **Is this condition or problem related to your current or former job? .....Yes □ No □**
11. **DID YOU GO TO THE HOSPITAL OR EMERGENCY ROOM FOR <u>THIS</u> CONDITION? ……Yes □ No □**

If "NO", please skip to the next section. If "YES", please continue to fill out this section.

Name of Facility:_____Location:_____

Did you go to the hospital by: □ Ambulance □ Car □ Other:_____

Were x-rays taken? □ **Yes** □ **No** If yes, of what body region(s)? _____

What was your diagnosis?_____

PATIENT HEALTH QUESTIONNAIRE

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

The information you provide concerning past and present symptoms and diseases assists your doctor in obtaining an early understanding of your state of health.

N = NEVER PA = PAST PR = PRESENT

N	PA	PR	CONDITION
			General Symptoms:
□	□	□	Headache
□	□	□	Nervousness
□	□	□	Tension
□	□	□	Anxiety
□	□	□	Irritability
□	□	□	Depression
□	□	□	Cold Hands or Feet
□	□	□	Night Sweats
□	□	□	Cold Sweats
□	□	□	Excessive Thirst
□	□	□	Abnormal Weight Loss
□	□	□	Abnormal Weight Gain
□	□	□	General Fatigue
□	□	□	Sleep Problems
			Musculoskeletal:
□	□	□	Neck Pain
□	□	□	Neck Stiffness
□	□	□	Jaw Pain
□	□	□	Shoulder Pain
□	□	□	Hand Pain
□	□	□	Upper Back Pain
□	□	□	Lower Back Pain
□	□	□	Pain in ankle or knee
□	□	□	Joint Swelling
□	□	□	Stiffness of Joint(s)
□	□	□	Arthritis
□	□	□	Pain in Upper Leg or Hip
□	□	□	Pain in Lower Leg or Knee
			Neurological symptoms:
□	□	□	Numbness in Fingers
□	□	□	Numbness in Toes
□	□	□	Pins and Needles
□	□	□	Fainting
□	□	□	Loss of Consciousness
□	□	□	Seizures/Convulsions
□	□	□	Dizziness
□	□	□	Balance Problems
□	□	□	Coordination Problems
□	□	□	Ringing in the Ears
□	□	□	Memory Problems
□	□	□	Eyes Sensitive to Light
□	□	□	Loss of Smell

N	PA	PR	CONDITION
			Cardiovascular Symptoms:
□	□	□	Palpitations (Racing Heart)
□	□	□	Chest Pains (Angina)
□	□	□	Shortness of Breath
□	□	□	High Blood Pressure
□	□	□	Low Blood Pressure
□	□		Stroke:
Date:_____			
□	□		Heart Attack:
Date:_____			
□	□		Coronary Artery Bypass
Date:_____			
□	□		Pacemaker for Heart
			Respiratory Symptoms:
□	□	□	Asthma
□	□	□	Chronic Cough
□	□	□	Chronic Sinusitis
□	□	□	Lung Problems
□	□	□	Allergic Rhinitis
			Urinary System Symptoms:
□	□	□	Frequent Urination
□	□	□	Painful Urination
□	□	□	Kidney Stones
□	□	□	Bladder Disorder
□	□	□	Kidney Disorder
□	□	□	Prostate Problem
□	□	□	Loss of Bladder Control
			Other Chronic Issues:
□	□	□	Skin Problems - Rash
□	□	□	Diabetes
□	□	□	Anemia
□	□	□	Other Blood Disorder(s)
_____			
□	□	□	Cancer:
Type:_____			
□	□	□	Other Condition(s):
_____			
_____			
_____			

N	PA	PR	CONDITION
			Digestive Symptoms:
□	□	□	Nausea
□	□	□	Vomiting
□	□	□	Loss of Appetite
□	□	□	Upset Stomach
□	□	□	Constipation
□	□	□	Diarrhea
□	□	□	Heartburn Indigestion
□	□	□	Loss of Bowel Control
□	□	□	Ulcer
□	□	□	Colitis
□	□	□	Irritable Colon
□	□	□	Anorexia/Bulimia
□	□	□	Difficulty Swallowing

General Health:

Height:_____

Weight:_____

Date of Last:

Physical Exam:_____

X-ray Exam:_____

Blood Test:_____

SOCIAL HISTORY:

□ □ □ Tobacco Use

□ □ □ Alcohol Use

□ □ □ Recreational Drug Use

WOMEN – Please fill out this section:

□ □ □ Pregnant

□ □ □ Irregular Menses

□ □ □ Profuse Menses

□ □ □ PMS

□ □ □ Menstrual cramps

□ □ □ Use Birth Control Pills

□ □ □ Sore Breast(s)/Lump(s)

□ □ □ Endometriosis

□ □ □ Vaginal Discharge

Date of Last Menses: _____

_____

Notice to Pregnant Women: All female patients must inform the supervising clinician if they know or suspect they are pregnant as some procedures and therapies may present a risk to the pregnancy.

PATIENT HEALTH QUESTIONNAIRE

Patient Name:_____**Date:**_____

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE.

1. Please list all ALLERGIES: _____

2. What is the most important reason for making this appointment today?_____

3. Please list any current medical conditions you have: _____

_____

_____

4. Please list any associated family health conditions of immediate family or relatives:

5. Please list all prescriptions, OTC medications, and nutritional/herbal supplements you are taking:

6. Please list any hospitalizations, surgeries, serious trauma, accidents, or falls you have had:

7. Have you ever been exposed to:

The AIDS virus (HIV) ..... **Yes** □ **No** □

Tuberculosis (TB) ..... **Yes** □ **No** □

Hepatitis virus (A, B, or C)? ..... **Yes** □ **No** □

8. Do you currently have a productive cough?..... Yes □ **No** □

9. How would you grade your overall stress level?

□ No Stress □ Minimal Stress □ Moderate Stress □ Greatly Stressed

10. What is your general physical activity <u>at</u> work?

□ Sitting more than 50% of the work day □ Light manual labor □ Moderate manual labor

□ Heavy manual labor

11. What is your general physical activity <u>outside of</u> work?

□ No regular exercise program □ Light exercise program □ Strenuous exercise program

12. How would you rate your overall diet?

□ Poor Diet □ Average Diet □ Healthy Diet □ Excellent Diet

13. On a scale of 1-10. How committed are you to resolving this complaint? _____

14. On a scale of 1-10. How important is your health to you? _____

15. How did you hear about Altorelli Chiropractic and Wellness? _____

I HEARBY CERTIFY THAT THE STATEMENTS AND ANSWERS GIVEN ON THIS FORM ARE ACCURATE TO THE BEST OF MY KNOWLEDGE AND I UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY HEALTH. I AGREE TO ALLOW THIS OFFICE TO EXAMINE ME FOR FURTHER EVALUATION.

Patient Signature: _____**Date:**_____

PATIENT FINANCIAL AGREEMENT

I understand the payment is due at the time services are rendered, unless prior financial arrangements have been made. We accept cash, check, and credit card.

PERSON RESPONSIBLE FOR THE BILL:

□ Please check this box if the **patient** is the person responsible for the bill and **do not fill out** this section.
□ Please check this box if the **parent/guardian** is the person responsible for the bill and **fill out** this section.

Last Name:_____First Name:_____MI:____
Date of Birth:____/____/_____SSN:_____Gender: □Male □Female
Street:_____Preferred Phone:_____
City:_____State:_____Zip:_____
Relationship to patient:_____

I,_____, have read the above information and information on the following page (page 6) and I understand the information provided within this document. This information has been explained to me and all questions which I have asked have been answered to my satisfaction.

_____ _____
Signature Date

_____
Print name here

If the patient is a minor or unable to consent:

_____ _____
Signature of person legally and/or financially responsible for the patient Date

_____
Print name of person legally authorized here

Insurance & Payment: Altorelli Chiropractic and Wellness, LLC

All new patients must have an initial examination and consultation before receiving chiropractic treatment. The initial visit is a comprehensive physical examination consisting of a detailed history, orthopedic, neurological, and chiropractic evaluations. Expect to spend 45 minutes to an hour for the first visit. The cost is $205.

For all visits, payment is made directly to the office at the time of your visit. We will gladly accept cash, checks, debit and credit cards. If you have health insurance, we will provide you with a computer-generated form that is properly coded with our procedures and your diagnosis which you can submit for reimbursement to your carrier.

Fees paid to doctors of chiropractic are allowable deductions as expenses for "medical care" for Federal income tax purposes.

If you have an **HSA**, you can deduct payment for chiropractic services using your linked debit card or checking account.

All Medicare Patients: Chiropractic manipulation of the spine is the only covered service. Physical examinations, including the initial exam, and all other therapies/services are not covered by Medicare.

Cancellation Policy:

Altorelli Chiropractic and Wellness, LLC has a 24 hour cancellation/ rescheduling policy. If you miss or cancel your appointment with less than 24 hours notice, you will be charged $50 the first time and full charge for every subsequent visit.

This policy is in place out of respect for our Doctor and our patients. Cancellations with less than 24 hours notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else, who needs treatment, from being able to schedule into that time slot. Thank you for your understanding and cooperation.