CARBONE CHIROPRACTIC CENTER, LLC

A New Approach to Healthy Living

NEW PATIENT REGISTRATION FORM

TODAY'S DATE: _____

NAME: _____ MALE_____ FEMALE_____

ADDRESS: _____ CITY: _____ STATE_____ ZIP _____

H ( ) _____ C ( ) _____ W ( ) _____

BEST NUMBER TO REACH YOU?_____ WOULD YOU LIKE APPT REMINDERS TO YOUR CELL? _____

IF YES, WHAT IS YOUR CELL PHONE PROVIDER/CARRIER (VERIZON, AT&T, SPRINT) _____

EMAIL ADDRESS_____ (USED FOR HEALTH NEWSLETTERS AND REMINDERS)

BIRTH DATE: _____ AGE: _____

LANGUAGE: _____ HEIGHT: _____ WEIGHT: _____

MARITAL STATUS (PLEASE CIRCLE): SINGLE MARRIED DIVORCED SEPARATED WIDOWED

SPOUSE'S NAME_____ NO. OF CHILDREN_____

OCCUPATION _____ EMPLOYER'S NAME_____

MOST PATIENTS ARE REFERRED TO OUR OFFICE BY A CARING FAMILY MEMBER OR FRIEND. WHAT MADE YOU DECIDE TO VISIT OUR OFFICE?

FRIEND'S NAME_____ FAMILY MEMBER'S NAME_____

WEBSITE_____ PRIMARY CARE _____ OTHER_____

HAVE YOU EVER RECEIVED CHIROPRACTIC CARE? YES NO

IF YES, WHEN AND WHERE? _____

IS THE REASON YOU ARE HERE TODAY DUE TO AN AUTO ACCIDENT OR WORKER'S COMP? _____

IF SO, PLEASE TELL OUR FRONT DESK, AS THERE MAY BE OTHER FORMS TO FILL OUT.

WHO IS YOUR:

PRIMARY CARE PHYSICIAN: _____ LAST VISITS: _____

MASSAGE THERAPIST: _____ LAST VISITS: _____

NUTRITIONIST: _____ LAST VISITS: _____

OTHER: _____ LAST VISITS: _____

WHY THIS FORM IS IMPORTANT

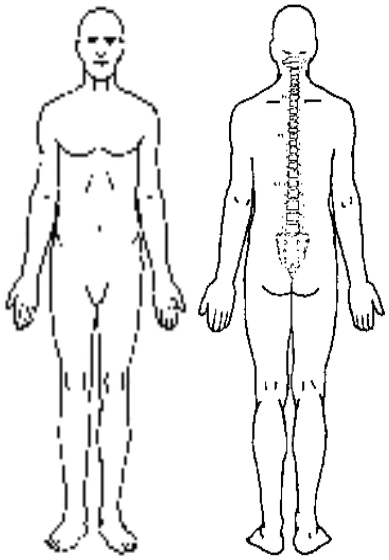
As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of continued wellness care. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual, not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

COMPLAINT/SYMPTOMS INFORMATION

List Complaint #1	Type of Pain:	Worse with which of these activities:	Result of:
_____ _____ Began? _____ HAVE YOU HAD THIS IN THE PAST? ☐ YES ☐ NO IS IT GETTING WORSE? ☐ YES ☐ NO	☐ ACHING ☐ STIFF ☐ BURNING ☐ TENDER ☐ SHOOTING ☐ SORE ☐ NUMB ☐ TIGHT ☐ TINGLING ☐ SHARP ☐ STABBING ☐ DEEP ☐ THROBBING	☐ LYING ON BACK ☐ STOOPING ☐ LYING ON SIDE ☐ BENDING ☐ LYING ON STOMACH ☐ SITTING ☐ TURNING OVER ☐ STANDING ☐ GETTING IN/OUT OF CAR ☐ PUSHING ☐ WALKING ☐ PULLING ☐ CLIMBING ☐ LIFTING ☐ SNEEZING ☐ REACHING ☐ COUGHING ☐ TWISTING/TURNING ☐ OTHER:_____ _____	☐ AUTO ACCIDENT ☐ WORK INJURY ☐ OTHER: _____ _____ _____
List Complaint #2	**Type of Pain:**	**Worse with which of these activities:**	**Result of:**
_____ _____ Began? _____ HAVE YOU HAD THIS IN THE PAST? ☐ YES ☐ NO IS IT GETTING WORSE? ☐ YES ☐ NO	☐ ACHING ☐ STIFF ☐ BURNING ☐ TENDER ☐ SHOOTING ☐ SORE ☐ NUMB ☐ TIGHT ☐ TINGLING ☐ SHARP ☐ STABBING ☐ DEEP ☐ THROBBING	☐ LYING ON BACK ☐ STOOPING ☐ LYING ON SIDE ☐ BENDING ☐ LYING ON STOMACH ☐ SITTING ☐ TURNING OVER ☐ STANDING ☐ GETTING IN/OUT OF CAR ☐ PUSHING ☐ WALKING ☐ PULLING ☐ CLIMBING ☐ LIFTING ☐ SNEEZING ☐ REACHING ☐ COUGHING ☐ TWISTING/TURNING ☐ OTHER:_____ _____	☐ AUTO ACCIDENT ☐ WORK INJURY ☐ OTHER: _____ _____ _____
List Complaint #3	**Type of Pain:**	**Worse with which of these activities:**	**Result of:**
_____ _____ Began? _____ HAVE YOU HAD THIS IN THE PAST? ☐ YES ☐ NO IS IT GETTING WORSE? ☐ YES ☐ NO	☐ ACHING ☐ STIFF ☐ BURNING ☐ TENDER ☐ SHOOTING ☐ SORE ☐ NUMB ☐ TIGHT ☐ TINGLING ☐ SHARP ☐ STABBING ☐ DEEP ☐ THROBBING	☐ LYING ON BACK ☐ STOOPING ☐ LYING ON SIDE ☐ BENDING ☐ LYING ON STOMACH ☐ SITTING ☐ TURNING OVER ☐ STANDING ☐ GETTING IN/OUT OF CAR ☐ PUSHING ☐ WALKING ☐ PULLING ☐ CLIMBING ☐ LIFTING ☐ SNEEZING ☐ REACHING ☐ COUGHING ☐ TWISTING/TURNING ☐ OTHER:_____ _____	☐ AUTO ACCIDENT ☐ WORK INJURY ☐ OTHER: _____ _____ _____

COMPLAINT INFORMATION CONTINUED

Please mark your areas of pain on the figures below:



IS THIS CONDITION INTERFERING WITH YOUR: ____ WORK

___ SLEEP___WALKING ___SITTING ___HOBBIES ___LEISURE

HAVE YOU RECEIVED ANY TREATMENT FOR THIS CONDITION? YES NO

IF YES, PLEASE EXPLAIN_____

HABITS

SMOKING	PACK/DAY_____
ALCOHOL	DRINKS/DAY_____
RECREATIONAL DRUGS	LIST_____
COFFEE	CUPS/DAY_____
SOFT DRINKS	DRINKS/DAY_____
WATER	CUPS/DAY_____

EXERCISE

☐ NONE
☐ 1-2 DAYS/WEEK
☐ 3-4 DAYS/WEEK
☐ 5+ DAYS/WEEK

TYPE: _____

_____

HOSPITALIZATIONS, SURGERIES, INJURIES

DO YOU HAVE A PACEMAKER? YES NO

HAVE YOU HAD KNEE OR HIP REPLACEMENT SURGERY? YES NO

HAVE YOU HAD BREAST IMPLANT SURGERY? YES NO

DO YOU HAVE ANY OTHER IMPLANTABLE MEDICAL DEVICE IN YOUR BODY? YES NO

PLEASE LIST ANY HOSPITALIZATIONS, SURGERIES OR INJURIES THAT YOU HAVE HAD (IF NONE, WRITE NONE)

Date Description

1 _____

2 _____

3 _____

4_____

5_____

MEDICATIONS AND SUPPLEMENTS

ARE THESE MEDICATIONS NECESSARY FOR YOU TO HAVE RELIEF AND/OR TO FUNCTION? YES NO

PLEASE LIST ANY MEDICATIONS (PRESCRIPTION AND OVER THE COUNTER) AND/OR SUPPLEMENTS/VITAMINS YOU ARE CURRENTLY TAKING AND WHY YOU ARE TAKING THEM:

1_____ 5_____

2_____ 6_____

3_____ 7_____

4_____ 8_____

*IF YOU NEED MORE ROOM PLEASE FILL IT OUT ON THE BACK OF THIS SHEET.

HEALTH HISTORY

PLEASE MARK ANY OF THE FOLLOWING THAT APPLY TO YOU:

□ HEADACHES	□ NECK PAIN	□ UPPER BACK	□ MID BACK PAIN
□ LOW BACK PAIN	□ WRIST/HAND PAIN	□ HIP PAIN	□ KNEE PAIN
□ ELBOW PAIN	□ ANKLE/FOOT PAIN	□ SHOULDER PAIN	□ CANCER
□ VISUAL PROBLEMS	□ ASTHMA	□ ANEMIA	□ ARTHRITIS
□ ALLERGIES/SINUS	□ CHEST PAIN	□ IBS	□ DIABETES
□ RINGING IN EARS	□ HIGH CHOLESTEROL	□ DIGESTIVE PROBLEMS	□ ULCERS
□ HIGH BLOOD PRESSURE	□ CONSTIPATION	□ AUTOIMMUNE DISEASE	□ SEIZURE
□ HYPOTHYROIDISM	□ HEMORRHOIDS	□ FIBROMYALGIA	□ HEPATITIS
□ ACID REFLUX	□ MUSCLE SPASMS/CRAMPS	□ WEIGHT (LOSS/GAIN)	□ TENSION
□ MULTIPLE SCLEROSIS	□ MENSTRUAL ISSUES	□ URINARY DIFFICULTIES	□ DIZZINESS
□ PINS/NEEDLES IN LEGS	□ LOSS OF SMELL	□ LOSS OF TASTE	□ IRRITABILITY
□ PINS/NEEDLES IN ARMS	□ LOSS OF BALANCE	□ BUZZING IN EARS	□ DEPRESSION
□ NUMBNESS IN FINGERS	□ NUMBNESS IN TOES	□ FATIGUE	□ HOT FLASHES
□ COLD HANDS	□ COLD FEET	□ COLD SWEATS	□ OTHER: _____

FAMILY HISTORY

HAVE ANY OF YOUR RELATIVES HAD ANY OF THE FOLLOWING CONDITIONS? IF YES, PLEASE LIST WHO (IF NONE, WRITE NONE). PLEASE INCLUDE: MOTHER, FATHER, GRANDPARENT, BROTHER, SISTER, AND CHILD.

1. HEART DISEASE_____
2. HEART FAILURE_____
3. CANCER _____
4. DIABETES _____
5. STROKE_____
6. HIGH BLOOD PRESSURE _____
7. KIDNEY DISEASE_____
8. AUTO-IMMUNE DISEASE _____
9. ARTHRITIS_____
10. OTHER: WHAT_____WHO_____

ADDITIONAL INFORMAION

DO YOU HAVE, OR EVER HAD, ANY DISEASES OR MEDICAL PROBLEMS NOT LISTED? ___YES ___NO

IF SO, PLEASE LIST_____

DO YOU HAVE ANY ALLERGIES? _____YES _____ NO

IF YES, PLEASE LIST _____

HAVE YOU RECEIVED THE FLU VACCINE? _____ YES _____NO WHEN: _____

ANY ADDITIONAL INFORMATION YOU WOULD LIKE THE DOCTOR TO KNOW ABOUT BEFORE BEGINNING CARE AT CARBONE CHIROPRACTIC CENTER? _____

_____

SIGNATURE_____ DATE_____

Patient Name: _____ Date: _____

Using the key below please circle one answer in each box that indicates your ability to do the following activities

Key: (0 = normal) (1 = minimally difficult) (2 = moderately difficult) (3 = very difficult) (4 = unable)

Activity	Score				
1. Sleep normally	0	1	2	3	4
2. Up and down stairs	0	1	2	3	4
3. Food Prep, cooking, eating	0	1	2	3	4
4. Walking	0	1	2	3	4
5. Grooming (bath, comb hair, shave, etc)	0	1	2	3	4
6. Getting up and down from a chair or bed	0	1	2	3	4
7. Dressing—manage normal dressing activities	0	1	2	3	4
8. Dressing—tie shoes, button shirt	0	1	2	3	4
9. Lifting, carrying up to 10 pounds	0	1	2	3	4
10. Sitting for normal periods of time	0	1	2	3	4
11. Standing for normal periods of time	0	1	2	3	4
12. Reaching above head or across body	0	1	2	3	4
13. Leisure, recreational, sports activities	0	1	2	3	4
14. Squatting down to pick up item	0	1	2	3	4
15. Running, jogging	0	1	2	3	4
16. Driving	0	1	2	3	4
17. Job requirements— can do all activities required of my job	0	1	2	3	4

Pain Scale: Please circle the number that describes the pain you have experienced over the last week with (

FINANCIAL RESPONSIBILITIES

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I authorize payment directly from my insurance company to Carbone Chiropractic Center. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are ultimately my personal responsibility. I also understand that if I suspend or terminate my care and treatment any fees for professional service rendered me will be immediately due and payable.

If I have insurance, I am responsible for my insurance deductible, co-payments and any service rejected by my insurance company. I am also aware that if I have not made a payment on my outstanding balance within a 30 day period, a service fee of 4 % will be added to my account. If I have an outstanding balance that may be served to a collection agency, there will be an additional fifty dollar fee added.

This office cannot promise that an insurance company will pay. In the event that the insurance company disputes or rejects the claim, we will pursue on your behalf as far as we are able to. If unsuccessful, you will be expected to take responsibility for any outstanding balance.

I authorize this office to release any information pertinent to my case to any insurance company, adjuster and/or attorney involved in this case, and hereby release this office of any consequences thereof.

Although our office will call to verify your insurance coverage, it is your responsibility to confirm and know your benefits. If you have limited coverage, you are responsible to know when your insurance will stop paying your claims.

I certify that the information provided in this four-part form is correct to the best of my knowledge. I will not hold my doctor or any staff member of Carbone Chiropractic Center responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian: _____Date: _____

ACKNOWLEDGEMENT AND UNDERSTANDING

I acknowledge and agree to the following:

The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

Chiropractic is not a treatment for any condition or symptom. It is a care system that is aimed toward the reduction and correction of spinal subluxations so that your body as a whole may function better.

Although Chiropractic care is one of the safest forms of health care, it is associated with some minor risks and it is my responsibility to be informed about those risks by asking the doctor or a staff member prior to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of Care in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another health care professional who we feel can further assist you.

I hereby authorize the doctors and staff affiliated with Carbone Chiropractic Center to care for my condition as deemed appropriate.

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian: _____Date: _____

CONSENT OF TREATMENT OF MINOR CHILD (18 and under)

I hereby authorize Dr. _____ and whomever he may designate as assistance to administer chiropractic care as he deems necessary to my _____ (indicate relationship to child).

Name of Child: _____ Date: _____

Signature of Parent or Guardian: _____

Signature of Staff: _____ Date: _____

CARBONE CHIROPRACTIC CENTER, LLC
at The Wellness Center

Guy Carbone, DC
Melissa Tulisano, DC
Christina Ruddy, DC
Matthew Carbone, DC
Andrew Crape, DC

82-86 Wolcott Hill Rd, Wethersfield, CT 06109
Phone: 860.296.4446 Fax: 860.296.0041
info@carbonechiropractic.com
www.carbonechiropractic.com

Acknowledgement of Receipt of Notice of Privacy Practices

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of ____Carbone Chiropractic Center, LLC___.

I understand that the Notice describes the uses and disclosures of my protected health information by Carbone Chiropractic Center, LLC and informs me of my rights with respect to my protected health information.

_____ _____
Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____
Today's Date *If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

_____ _____
Employee Name *Today's Date*

PATIENT INFORMATION RELASE AUTHORIZATION

I, _____, hereby authorization Carbone Chiropractic Center, to release information contained in my patient records to the individual(s) and only under the conditions listed below:

1. Name of person(s) to whom information can be disclosed to:

_____

_____

_____

2. Specific type of information to be disclosed:

_____

_____

_____

***PLEASE NOTE THAT THIS AUTHORIZATION RELEASE IS EFFECTIVE UNTIL WRITTEN NOTIFICATION IS RECEIVED BY OUR OFFICE REVOKING AND/OR CHANGING AUTHORIZATION**

_____ _____

Patient's Signature Witnessed By

_____ _____

Date Signed Date Witnessed

_____ _____

Signature of Parent or Guardian Date Signed