Welcome to Capaccio Chiropractic

Confidential

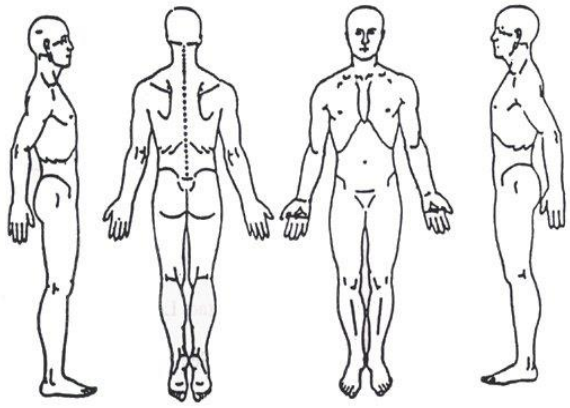
Patient Information - Please Print DATE: ____/_____/_____

Name: _____ SSN: _____
Address: _____ City: _____ State: _____ ZIP: _____
Home #: (_____)_____ Cell # (_____)_____ DOB: ____/____/_____
Email: _____
Are you: ☐ Single ☐Married ☐Divorced ☐Widowed
Employer: _____ Title: _____
Do you work ☐Full Time ☐Part Time ☐Retired Work #: _____
Whom may we thank for referring you? _____
Emergency Contact: _____ _____ _____
(Name) (phone) (relationship)

SYMPTOMS – Please Print

Reason for visit: _____
When did this start? _____
What brought this on? _____
Is this condition getting: ☐Progressively Worse? ☐ Same? ☐Better?
What activities are difficult to perform? ☐SittingStanding ☐Walking ☐Bending ☐Lying Down
Other (explain): _____

Use the letters below to indicate the type and location of your Sensations right now on the drawing to the right ….



Rate the severity of your pain
with 1=mild and 10=severe
Neck: ____:10
Mid Back ____:10
Low Back ____:10

Is your pain ☐Constant ☐Comes and Goes
Has this pain occurred before? ☐Yes ☐No

Have you seen anyone else for this condition before? ☐Yes ☐No
If yes, please provide the name below – they will not be contacted.
Name of Doctor: _____ Treatment Type: _____
Did the treatment help? _____

Health History

Check only those conditions which are applicable:

☐ AIDS/HIV	☐ Depression	☐ High Blood Pressure	☐ Pneumonia
☐ Alcoholism	☐ Diabetes	☐ Kidney Disease	☐ Prostate Disease
☐ Anemia	☐ Emphysema	☐ Liver Disease	☐ Prosthesis
☐ Arthritis	☐ Fractures	☐ Measles	☐ Psychiatric
☐ Asthma	☐ Gout	☐ Migraines	☐ Rheumatoid Arthritis
☐ Bleeding Disorders	☐ Heart Disease	☐ Multiple Sclerosis	☐ Stroke
☐ Bronchitis	☐ Hepatitis	☐ Osteoporosis	☐ Tuberculosis
☐ Cancer	☐ Hernia	☐ Pacemaker	☐ Tumors/Growths
☐ Chicken Pox	☐ Herniated Disc	☐ Parkinson's Disease	☐ Ulcers

☐ Other: _____

Please list any surgeries and/or Fractures you have had and the dates:

_____

_____

Medications you currently take (check all that apply):

☐ Pain Killers	☐ Muscle Relaxers	☐ Insulin	☐ Blood Pressure
☐ Blood Thinners	☐ Cholesterol	☐ Cardiac (Heart)	☐ Vitamins/Supplements
☐ Over the Counter	☐ Other		

Women: Any chance that you may be pregnant? ☐ Yes ☐ No

Daily Habits:

What type of exercise do you perform daily? ☐ None ☐ Moderate ☐ Heavy

Your daily work habits include? ☐ Sitting ☐ Standing ☐ light labor ☐ heavy labor ☐ Computer Work

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorized Dr. Rita Capaccio, Chiropractor, to release any information including the diagnosis and the records of treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Rita Capaccio D.C., Capaccio Chiropractic, insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the bill of service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ _____/_____/_____

(Signature) Date

Consent for Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during, the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I,_____have read and fully understand the above statements. (print name)

All questions regarding the doctor's objectives pertaining to my care in this have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____

(signature) (date)

Consent to evaluate and adjust a minor child

I, _____being the parent or legal guardian of _____ Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____

(signature) (date)