CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

PATIENT INFORMATION

1. LAST NAME _____ FIRST NAME _____ 3. MI _____

4. ADDRESS _____

5. CITY _____ 6. STATE _____ 7. ZIP_____

8. HOME (___) _____ 9. WORK (___)_____ 10. CELL (___) _____

11. AGE __ 12. DATE OF BIRTH ___/___/___ 13. SEX ☐ M ☐ F 14. SOC. SEC.# _____-__-_____

15. MARITAL STATUS ☐ S ☐ M ☐ D ☐ W 16. SPOUSE'S NAME _____

17. EMERGENCY CONTACT:_____

PHONE NUMBER:_____

RELATIONSHIP:_____

18. PRIMARY CARE PHYSICIAN:_____

ADDRESS:_____

TELEPHONE: (_____) _____ FAX: (_____) _____

WORKERS COMPENSATION INFORMATION

1. EMPLOYER & OCCUPATION _____

2. ADDRESS _____

3. CITY _____ 4. STATE _____ 5. ZIP _____

6. BUSINESS PHONE # (_____) _____ 7. FAX # (_____)_____

INSURANCE INFORMATION

1. INSURANCE TYPE: ☐ MEDICARE ☐ MAJOR MED ☐ AUTO ☐ LIEN ☐ WORK COMP

2. INSURED'S NAME _____ 3. INSURED'S SS# ___/___/____

4. PATIENT'S RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ _____

5. NAME OF INS. CO. _____ 6. INS. PHONE (___)_____

7. INSURANCE AGENT _____ 8. AGENT'S PHONE (___)_____

9. INS. CO. ADDRESS _____

10. POLICY # _____ 11. CLAIM # _____

12. NAME OF ATTORNEY _____

ATTORNEY ADDRESS:_____

ATTORNEY TELEPHONE: (_____) _____ ATTORNEY FAX: (_____) _____

Doctor's Initials ___

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Confidential Patient Questionnaire

Name: Date:

Major Complaint(s):

CHECK YOUR PRESENT AND PAST SYMPTOMS

Present	Past		Present	Past	
☐	☐		☐	☐	
☐	☐	Neck Pain	☐	☐	Excessive Thirst
☐	☐	Middle Back Pan	☐	☐	Chronic Cough
☐	☐	Low Back Pain	☐	☐	Sinus Problems
☐	☐	Headache	☐	☐	Chronic Fatigue
☐	☐	Dizziness	☐	☐	Painful Urination
☐	☐	Convulsions	☐	☐	Frequent Urination
☐	☐	Fainting, Visual Problems, Nausea	☐	☐	Difficulty with Bladder/Bowels
☐	☐	Shoulder Pain	☐	☐	Stomach Pain
☐	☐	Pain in Shoulder, Arms, Elbows	☐	☐	Difficult Swallowing
☐	☐	Pain in Hands	☐	☐	Depression
☐	☐	Pain in Upper Leg	☐	☐	High Blood Pressure
☐	☐	Pain in lower Leg	☐	☐	Angina
☐	☐	Pain in Ankle/Foot	☐	☐	Heart Attack
☐	☐	Swelling/Stiffness in Joints	☐	☐	Stroke
☐	☐	Jaw Pain	☐	☐	Asthma
☐	☐	Ringing in Ears	☐	☐	Cancer
☐	☐	Rapid Heart Beat	☐	☐	Emphysema
☐	☐	Chest Pain	☐	☐	Arthritis
☐	☐	Loss of Appetite	☐	☐	Diabetes
		Other _____			Ulcers

Please describe your current pain: __ Sharp __Dull __ Aches __Sore __Weak __ Throbbing
__Shooting __Constricting __Burning __Tingling

Was your problem from a: __Car Accident __Work Related Injury __Other

Was the onset: __Sudden __Gradual __Other

Briefly describe how the problem began: _____

What treatment have you received for this condition: _Family Doctor _Chiropractic _Physical Therapy
__Medical Specialist __Surgery __Injections __X-Ray __MRI Other_____

Have you ever had this problem before? __ Yes __No

What makes the problem better? ☐Nothing ☐Lying Down ☐Walking ☐Sitting Other_____

What makes the problem worse? ☐Nothing ☐Lying Down ☐Walking ☐Sitting Other_____

Are you currently working? _Yes _No If so, are you taking anything to control the pain? _Yes _No

If yes, do you: __Sit more then 50% of the day __Light Manual Labor _Heavy Manual Labor

Does Your Problem Affect Your Daily Activities? __No __Mild __Moderate __Significant Restrictions

Describe: (Work, Education, Social, Domestic, Hobbies)

Do you Smoke? __No __Yes ___Packs per Day

Do you Drink Alcohol? __No __Socially __Habitually

Doctor's Initials ___

Are you Pregnant? __No __Yes Date of Onset of Last Menstrual Period _____

Are you Currently Taking Medication? ___No __Yes Please List all Medicaltions

Do you have Any Allergies to Drugs or Other Products? __No __Yes Seasonal? __No __Yes

Describe:

FAMILY HISTORY

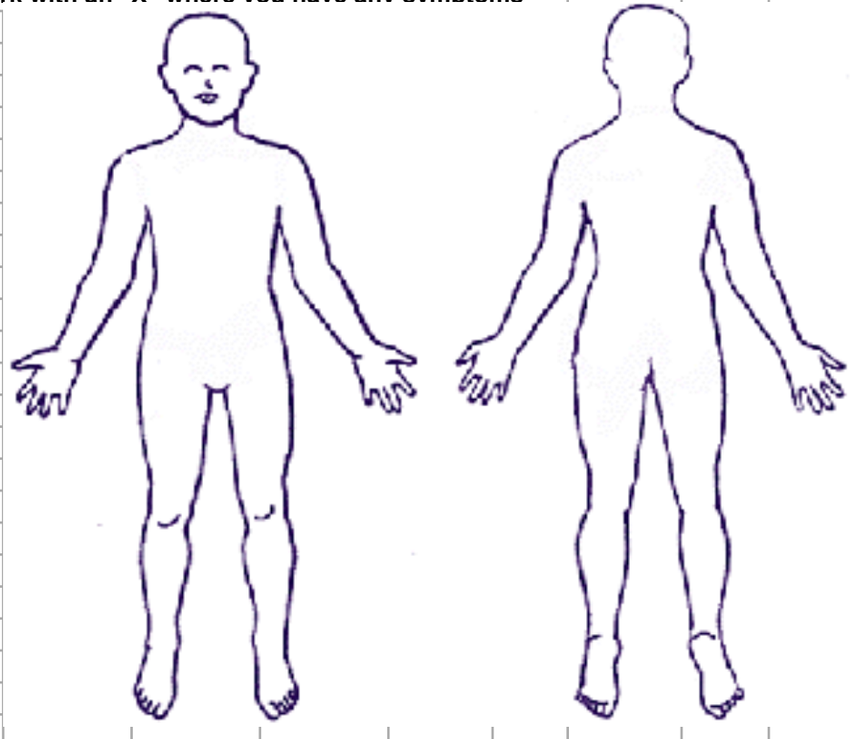
	Alive	Diabetes	Heart	Blood Pressure	Kidney	Cancer	Stroke	Other
Mother	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐	☐
Grandmother	☐	☐	☐	☐	☐	☐	☐	☐
Grandfather	☐	☐	☐	☐	☐	☐	☐	☐

Current Work Status:

- ☐ I Have Not Missed Any Days of Work
- ☐ I Have Missed ___ Days of Work
- ☐ I Have Been Put on Light Duty at Work
- ☐ I Have Had to Change my Job as a Result of my Condition

PAIN / SYMPTOM PICTURE

Please mark with an "X" where you have any symptoms



Patient or Legal Guardian Signature _____ **Date:** _____

Doctor's Initials ___

Consent to Treatment and Privacy Policy

I _____ authorize Dr. Ronald Salvaggione to perform chiropractic adjustments, treatments and procedures. I further consent to examinations, consulting services and diagnostic procedures rendered in conjunction with the adjustments, treatments and procedures.

Release of Information

Dr. Ronald Salvaggione may disclose information from the patient's records to doctors, hospitals or others for continuous care and to any third party who requires that information in order to fulfill and obligation benefiting the patient.

Responsibility for Payment

I acknowledge my responsibility to and agree to pay in full for the professional services rendered. I understand that the doctor may bill my health insurer for the services; such billing does not relieve me of my responsibility to pay for the services. I also understand a charge will be made for broken appointments unless 24 hours' notice is given. I agree to pay for any costs incurred as a result of sending my bill to a collection agency or any other legal action as well as 1.5% interest per month on any money owed for service rendered.

Informed Consent of Risks

I understand that chiropractic care, as with any health intervention, has inherent risks. These risks, though rare, could occur ranging from a minor aggravation of current condition to serious conditions such as cerebral vascular accidents. I also understand that the doctor is not liable for any problems that might arise if I decide not to follow the treatment in which he prescribes. I understand and am informed that , as in the practice of medicine, in the practice of chiropractic there are some risks to chiropractic care, including but not limited to sprain and strain, fractures, dislocations and general aggravations of inflammatory conditions. I understand that I will have an opportunity to discuss with the doctor and/or other office personnel the nature and purpose of the chiropractic procedures I will receive. I understand that the doctor and/or intern will perform an examination in order to minimize any risk or; however, I do not expect the doctor and/or intern to be able to anticipate and explain all risks and complications. I therefore wish to rely on the doctor and/or intern to exercise judgement during the course of the procedure which the doctor and/or intern feels at the time, based upon the facts as then known, is in my best interest.

Medicare Patients Authorization and Assignment of Benefits

I authorize payment of government benefits to Alta Vista Chiropractic who accepts assignment for services covered by Medicare. I also understand it is my responsibility to pay for all other services which Medicare does not cover.

CVA Signs

If during your visit you suffer from any of the following please notify the doctor or staff immediately.

1. Sudden severe pain in the side of your head and/or neck
2. Vision problems
3. Numbness, loss of feeling, or abnormal feeling
4. Weakness, clumsiness, or loss of strength
5. Loss of consciousness or momentary blackouts
6. Hearing problems
7. Disorientation or confusion
8. Speech problems
9. Dizziness

I have read, or have had read to me, the above consent and reviewed the information herein and represent that the same is true, correct and complete. I understand that the doctor is relying upon the information in rendering treatment. By signing below, I agree to the procedures. I intend this consent form to cover the entire course of care for my present condition(s) and for any future condition(s) for which I seek care.

Privacy Policy (HIPPA)

I acknowledge that Colorado Springs Spine & Injury Clinic's "Notice of Privacy Policies" has been provided to me. I understand that I have the right to review the Privacy Policy prior to signing this document. The Privacy Policy describes my rights with respect to my protected health information which is used for treatment, the payment of bills, and in the performance of health care operations of Colorado Springs Spine & Injury Clinic. Colorado Springs Spine & Injury Clinic reserves the right to change the privacy practices that are described in the "Notice of Privacy Policies". I understand that I may obtain a revised copy of the policies by calling the office and requesting a copy or by asking for one at the time of my next appointment.

Signature: _____ Date: _____

Relationship to Patient: _____