



Dr. Nicholas J. Senuta & Associates

Today's Date

How did you hear about us? \*family \_\_\_ \*friend \_\_\_ \*dr. \_\_\_ \*ins. co. \_\_\_ \*yellow pages \_\_\_
\*drive-by \_\_\_ \*hospital \_\_\_ Whom may we thank for referring you? \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Email Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Sex: M F M S W D Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Employers Address: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Employer: \_\_\_\_\_

What is the reason for your visit? \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ What activities aggravate
your condition? \_\_\_\_\_

Have you had this condition in the past? Y N Is this condition progressively getting worse? Y N

Does your condition interfere with your Work [ ] Sleep [ ] Daily Routine [ ] Other \_\_\_\_\_

How long has it been since you felt good? \_\_\_\_\_

Have you seen any other chiropractors this year? Y N How many visits? \_\_\_\_\_

What other treatments have you had for this condition? Physical therapy? Medications? Surgery?

Insurance Information

Who is responsible for this account? \_\_\_\_\_

Who is the Health Insurance Carrier? \_\_\_\_\_

ID card # \_\_\_\_\_ Group # \_\_\_\_\_

Policy holder's name: \_\_\_\_\_ Relationship: \_\_\_\_\_

DOB of policy holder: \_\_\_\_\_

Emergency Contact Information

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Date of last: Physical Exam \_\_\_\_\_ Spinal x-ray \_\_\_\_\_ Blood Test \_\_\_\_\_

Spinal Exam \_\_\_\_\_ Chest x-ray \_\_\_\_\_ Urine Test \_\_\_\_\_

Dental x-ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

Table with 3 columns: Injuries/Surgeries you have had, Description, Date. Rows include Fall, Head Injuries, Broken Bones, Dislocations, Surgeries.

**PAST MEDICAL HISTORY**

Have you ever been diagnosed as having or have suffered from? Place a check mark by conditions that apply to you.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Broken or fractured bones | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Circulatory Problems      | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Alcoholism      |
| <input type="checkbox"/> Rheumatoid Arthritis      | <input type="checkbox"/> Pace maker     | <input type="checkbox"/> Drug Addiction  |
| <input type="checkbox"/> Seizures/convulsions      | <input type="checkbox"/> Strokes        | <input type="checkbox"/> HIV Positive    |
| <input type="checkbox"/> Congenital Disease        | <input type="checkbox"/> Cancer         | <input type="checkbox"/> Gall Bladder    |
| <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Ruptures       | <input type="checkbox"/> Depression      |
| <input type="checkbox"/> High/Low Blood Pressure   | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Ulcers          |

Please circle all the activities that you find difficult to do now due to your discomfort?

- |                                  |  |                                     |
|----------------------------------|--|-------------------------------------|
| *Sleep through the night         | *Crawl on all fours                          | *Push or pull vacuum or lawn mower  |
| *Get out of bed                  | *Carry laundry, groceries or child           | *Turn door knob                     |
| *Make your bed                   | *Open heavy door                             | *Wash windows or walls              |
| *Bathe yourself                  | *Sit in a chair for 30 min.                  | *Shovel snow or dirt                |
| *Wash, comb or dry hair          | *Sit and work at a desk for one hour         | *Bend over to clean bathtub         |
| *Go to the bathroom              | *Use pencil, scissors, screwdriver or pliers | *Get up from low seat               |
| *Put on socks, shoes or clothing | *Cross legs                                  | *Lift heavy suitcase (40Lbs.)       |
| *Walk up one flight of stairs    | *Reach in front or overhead to high shelves  | *Walk one mile                      |
| *Walk down one flight of stairs  | *Stand for 30 minutes                        | *Enjoy hobbies or social activities |
| *Bend over sink for 10 minutes   | *Travel on journeys that take over one hour  | *Enjoy sexual activities            |

Did you have difficulty with any of the above activities before you had this condition? Y N  
 What activities? \_\_\_\_\_

**FAMILY DISEASES (check if applicable and indicate whether family member is Father, Mother, Sister, Brother)**

- |                    |                      |                      |
|--------------------|----------------------|----------------------|
| Tuberculosis _____ | Cancer _____         | Mental Illness _____ |
| Diabetes _____     | Asthma _____         | Heart Disease _____  |
| Stroke _____       | Kidney Disease _____ | Lung Disease _____   |
| Arthritis _____    | Liver Disease _____  |                      |

Medications	Allergies	Vitamins/Herbs Minerals

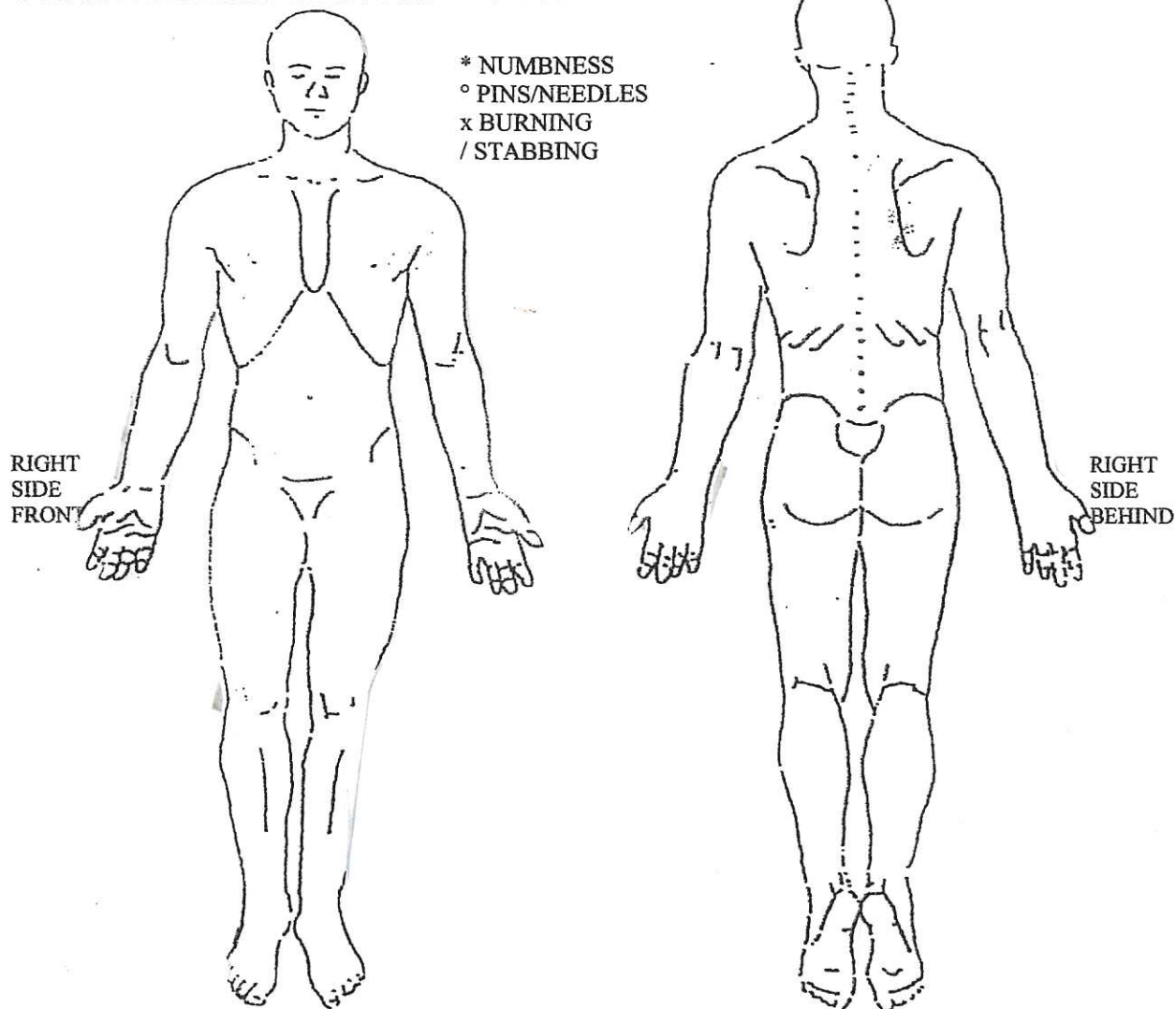
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and the patient. Furthermore, I understand that the Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company that any amount authorized to be paid directly to Chiropractic Clinic will be credited to my account upon receipt. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable. I hereby authorize the doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agree the amount paid the doctor, x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Print Name: \_\_\_\_\_

Dr. Nicholas J. Senuta & Associates

Name: \_\_\_\_\_ Date: \_\_\_\_\_

USING THE SYMBOLS BELOW, PLEASE MARK THE AREAS ON YOUR BODY WHERE YOU HAVE DECREASE IN FUNCTION OR PAIN.



PUT A CIRCLE AROUND THE AREAS THAT HURT NOW

USE THE FOLLOWING SCALES TO GRADE THE INTENSITY OF YOUR PAIN

CIRCLE THE NUMBER TO INDICATE YOUR PAIN LEVEL WHEN THE PROBLEM BEGAN

0 1 2 3 4 5 6 7 8 9 10  
+++++

MILD SEVERE  
MODERATE

CIRCLE THE NUMBER TO INDICATE YOUR PAIN LEVEL NOW

0 1 2 3 4 5 6 7 8 9 10  
+++++

MILD SEVERE  
MODERATE

Patient's signature \_\_\_\_\_



**IMPORTANT: PLEASE (X) ALL PRESENT SYMPTOMS**

**HEAD:**

- headache
- sinus
- entire head
- back of head
- forehead
- temples
- migraine
- head feels heavy
- loss of memory
- light-headedness
- fainting
- light bothers eyes
- blurred vision
- double vision
- loss of vision
- loss of taste
- loss of balance
- dizziness
- loss of hearing
- pain in ears
- ringing in ears
- buzzing in ears

**NECK:**

- pain in neck
- neck pain with movement
- forward
- backward
- turn to left
- turn to right
- bend to left
- bend to right
- pinched nerve in neck
- neck feels out of place
- muscle spasms in neck
- grinding sounds in neck
- popping sounds in neck
- arthritis in neck

**SHOULDERS:**

- pain in shoulder joint (R-L)
- pain across shoulders
- bursitis (R-L)
- arthritis (R-L)
- can't raise arm
- above shoulder
- over head
- tension in shoulders
- pinched nerve in shoulder
- muscle spasms in shoulders

**MID-BACK:**

- mid-back pain
- pain between shoulder blades
- sharp stabbing
- dull ache
- pain from front to back
- muscle spasms
- pain in kidney area

**CHEST:**

- chest pain
- shortness of breath
- pain around ribs
- breast pain
- irregular heartbeat

**ABDOMEN:**

- nervous stomach
- nausea
- gas
- constipation
- diarrhea
- hemorrhoids

**LOW BACK:**

- low back pain
- upper lumbar
- lower lumbar
- sacroiliac
- low back pain is worse when:
- working
- lifting
- stooping
- standing
- sitting
- bending
- coughing
- lying down (sleeping)
- walking
- pain relieves when? \_\_\_\_\_
- slipped disk
- low back feels out of place
- muscle spasms
- arthritis

**HIPS, LEGS & FEET:**

- pain in buttocks (R-L)
- pain in hip joint (R-L)
- pain down leg (R-L)
- knee pain
- leg cramps
- cramps in feet (R-L)
- pins & needles in legs (R-L)
- numbness of leg (R-L)
- numbness of toes

**WOMEN ONLY:**

- menstrual pain Y N
- cramping
- irregularity
- cycle \_\_\_ days
- birth control
- hysterectomy
- genital cancer
- menopause
- tumors
- abortions
- Are you pregnant?

**MEN ONLY:**

- urinary frequency
- night urination
- prostate pain or swelling

**GENERAL:**

- nervousness
- irritable
- depressed
- fatigue
- feeling run down
- normal sleep
- loss of sleep
- loss of weight
- gain weight
- coffee \_\_\_ cups/day
- tea \_\_\_ cups/day
- cigarettes \_\_\_ pk/day
- other \_\_\_\_\_

**ARMS & HANDS:**

- pain in upper arm
- pain in elbow
- tennis elbow
- pain in forearm
- pain in hands
- pain in fingers
- sensation of pins & needles in arms
- sensation of pins & needles in fingers
- numbness in arms (R-L)
- fingers go to sleep
- hands cold
- swollen joints in fingers
- sore joints in fingers

## TERMS OF ACCEPTANCE

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: to eliminate misalignments within the spinal column, which interfere with the expression of the body's innate wisdom. It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

Chiropractors provide a unique service that other healthcare providers do not offer: the location and correction of vertebral subluxations (spinal nerve stress) in your body.

**Vertebral Subluxation Complex (VSC):** a misalignment of one or more of the 24 vertebrae 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.

Chiropractors spend years studying how to locate and correct this destructive condition, first by analyzing your body structure (especially your spine) using various methods. Second, we correct or adjust your subluxation by using specialized techniques (spinal adjustment). When your spine and nervous system are free from the deep stress of vertebral subluxations you function more efficiently and your natural health ability, your inner healer, will better communicate through your body.

### **Informed Consent for Chiropractic Care**

A patient, in coming to the Chiropractor, gives the doctor permission and authority to care for the patient in accordance with the Chiropractic examinations, diagnosis and analysis. The chiropractic adjustment or other clinical procedures is usually beneficial and seldom cause a problem. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The



doctor, of course will not give a chiropractic adjustment, or health care, if he is aware that such care may be contradicted.

Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illness, or deformities which would otherwise not come to the attention of the Chiropractor. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Chiropractor provides a specialized, non-duplicating health service. The doctor of Chiropractic is licensed in a special practice of health care and is available to work with other types of providers in your health care regiment.

## RESULTS

The purpose of Chiropractic services is to promote natural health through the reduction of the VSC (defined earlier). Since there are so many variables, it is difficult to predict the time schedule of efficiency of the Chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions, which do not respond chiropractically, may come under control or be helped through medical science. The fact that the science of Chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have great strides in alleviating pain and controlling disease.

The patient should discuss any questions or problems with the doctor before signing this statement of policy.

I have read the foregoing and understand it.

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Signature

Date



Dr. Nicholas J. Senuta & Associates

**NO INSURANCE PAYS 100% OF EVERYTHING**

Insurance information is the responsibility of the patient. A phone number is located on the back of your card. They will tell you if you have chiropractic coverage. They will also tell you what your deductible is, if any. Also what coinsurance you may be responsible for.

If you prefer you may ask our insurance department to check this information for you. But please be advised, most insurance companies will not disclose deductible information to an outside source. It is considered confidential, and they will discuss it only with the patient.

Any information given to you by our insurance department is what they were told at the time of their conversation with your insurance company. It is not a guarantee of payment or amount. This will only be confirmed when an Explanation of Benefits is received.

If you paid any co pay or deductible that was not charged by your insurance on the explanation of benefits, it will be promptly refunded.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

