**Date** _____

**Print Full Name:** _____

The SIDOTI CENTER Chiropractic
*Passionatley Commited to Health*

Date of Birth: _____ ☐ Male ☐ Female | Soc. Sec #: _____

Street Address: _____

City/State/Zip: _____

Cell #: _____ Email: _____ # of Children ___ Ages _____

Have you been to our office before? ☐ No ☐ Yes | If Yes, about how long ago: _____

**Referred by:** ☐ Google ☐ Sign ☐ My Doctor | Dr. Name: _____

☐ Friend or Patient (Name): _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Significant Other (Name) _____

Are You Working ☐ No ☐ Yes | Occupation: _____ Employer: _____

Do You Have Health Insurance: ☐ No ☐ Yes | If Yes: ☐ Ins Name: _____

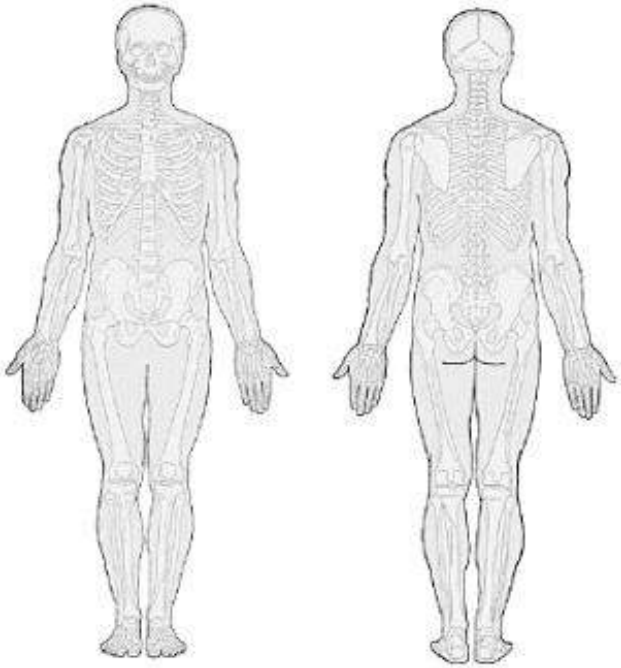
Have you had an Auto or Work injury in the past 2 years? ☐ No ☐ Yes | If Yes, When _____

Do you have an attorney? ☐ No ☐ Yes (Name) _____ Do you plan to get an attorney? ☐ No ☐ Yes

## LIST YOUR HEALTH CONCERNS BELOW

| List Health Conditions According to Severity | When Did This Conditon Begin? | Did The Condition Start With an Injury? (Describe) | Is this getting Better/Worse/Same |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |

**Please mark problem area below**



## CHECK CURRENT PROBLEMS THAT YOU HAVE

| | | |
|---|---|---|
| ☐ Headache __x____ | ☐ Loss of energy | ☐ High blood pressure |
| ☐ Migraines __x____ | ☐ Stomach disorder | ☐ Sleeping problems |
| ☐ Sinus problems | ☐ Irritable bowel | ☐ Jaw / TMJ Pain |
| ☐ Nervousness | ☐ Gastric reflux | ☐ Neck pain |
| ☐ Anxiety | ☐ Diarrhea | ☐ Shoulder pain ☐ L ☐ R |
| ☐ Dizziness | ☐ Ulcers | ☐ Arm pain ☐ L ☐ R |
| ☐ Vertigo | ☐ Constipation | ☐ Numbness in arms |
| ☐ Nausea | ☐ Chronic fatigue | ☐ Numbness in hands |
| ☐ ADD/ADHD | ☐ Throat issues | ☐ Mid back pain |
| ☐ Infertility | ☐ Gastric reflux | ☐ Chest / Rib pain |
| ☐ Allergies | ☐ Bladder problems | ☐ Low back pain |
| ☐ Depression | ☐ Kidney problem | ☐ Hip pain ☐ L ☐ R |
| ☐ Ear infections | ☐ Menstrual Cramps | ☐ Leg pain ☐ L ☐ R |
| ☐ Thyroid problem | ☐ Epilepsy | ☐ Knee pain ☐ L ☐ R |
| ☐ Asthma | ☐ Heart disorder | ☐ Numbness in legs |
| ☐ Other_____ | ☐_____ | ☐ Numbness in feet |

# Check Any Conditions You Have Now or Have Had:

□ Stroke □ Cancer □ Heart Disease □ Spinal Surgery

□ Scoliosis □ Diabetes □ Osteoporosis □ Spinal Bone Fracture

□ Seizures □ **NONE OF THE ABOVE CHECK THIS BOX**

**List all surgical operations and years**:

_____

_____

**List all over-the-counter & prescription medications you are on, and the reason for each:**

Medication_____ Reason_____

Medication_____ Reason_____

Medication_____ Reason_____

Medication_____ Reason_____

Medication_____ Reason_____

Medication_____ Reason_____

**Have you ever been knocked unconscious?** □ No □ Yes if yes, explain_____

## Social History

1. **Smoking**: □ Cigars □ Marijuana □ Cigarettes → **How often?** □ Daily □ Weekends □ Occasionally
2. **Alcoholic beverage**: Consumption → □ Daily □ Weekends □ Occasionally □ Never
3. **Recreational drug use**: Consumption → □ Daily □ Weekends □ Occasionally □ Never
4. **Hobbies**: Does your present problem affect: □ Recreational activities □ Exercise regime
   Please explain: _____

**Family Health History**

*This Section is to Assist the Doctors by Providing the Doctors with a Past Health History*

Place and **X** in the column that applies

| **Condition** | Spouse | Son | Daughter | Mother | Father |
|---|---|---|---|---|---|
| ADD/ADHD | | | | | |
| Arthritis | | | | | |
| Back Trouble | | | | | |
| High Blood Pressure | | | | | |
| Heartburn | | | | | |
| Fatigue | | | | | |
| Headaches | | | | | |
| Irregular Sleep Pattern | | | | | |
| Fibromyalgia | | | | | |
| Neck Pain | | | | | |
| Menstrual Cramps | | | | | |

# *Acknowledgements-Authorization-Assignments*

***PLEASE INITIAL***
***EACH LINE BELOW***

_____ ***INITIAL*** **AUTHORIZATION TO RELEASE INFORMATION & CONSENT TO APPEAL:** I authorize the release of any information concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result professional services rendered to myself and/or my dependants. I further consent to any Appeal (on my behalf) of any denial of procedures and/or treatment for previous or future care. I hereby release you of any consequences thereof.

_____ ***INITIAL*** **ASSIGNMENT OF PAYMENT:** I authorize and direct my insurance carrier to pay directly to Thomas J. Sidoti, D.C. any monies due on my account, or, authorize and direct that my bodily injury attorney to pay directly to Thomas J. Sidoti any monies due on my account directly from any settlement made on my behalf. Further, I agree to pay the difference, if any, between the total amount of his charges and the amount paid him by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay the charges should my condition be such that it is not covered by my policy or if for any reason the insurance company and/or attorney refuses to pay on my claim. A copy or facsimile of this authorization may be used in place of this original.

_____ ***INITIAL*** **MEDICARE ASSIGNMENT:** I authorize the release of any medical or other information about me to the Social Security Administration and the Health Care Financing Administration or its successors, intermediaries or carriers any information needed to process a Medicare claim on my behalf or on behalf of my dependants. I permit a copy or facsimile of this authorization to be used in place of the original. I also assign payment of medical benefits directly to Sidoti Chiropractic Center for services performed at Sidoti Chiropractic Center.

_____ ***INITIAL*** **CONSENT TO TREAT A MINOR CHILD:** I hereby authorize Thomas J. Sidoti, D.C., and whomever he may designate as his assistants to administer chiropractic care as he deems necessary to my dependants/relatives.

_____ ***INITIAL*** **FEMALES: ARE YOU PREGNANT?** **YES** **NO**

_____ ***INITIAL*** **ACKNOWLEDGMENT AND UNDERSTANDING:** I hereby acknowledge that I am receiving, or about to receive, health care services at Sidoti Chiropractic Center and that I have been advised that this office agrees to wait for payment of these services provided that there continues to be a reasonable chance that payment for these services will be made either by the insurance proceeds or out of the settlement of any liability case.

_____ ***INITIAL*** **NOTICE OF PATIENT PRIVACY PRACTICES:** I have read a copy of the Patient Privacy Practices for Sidoti Center.

I understand that if it is determined that either (1) That there is no insurance company obligated to pay for these services, or if the insurance company involved refuses to acknowledge an assignment to this office, or make other provisions for the protection of the interest of the office, or (2) If a liability claim exists and my attorney refuses to agree to protect the interest of this office, or if I have not engaged the services of an attorney; then payment of services rendered at this office will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last treatment, whichever comes first.

_____ _____
Name Printed Date

_____ _____
Signature Witness

# Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

*I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.*

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

# Electronic Health Records Intake Form

*In compliance with requirements for the government EHR incentive program*

**First Name**:_____ **Last Name**:_____

**Email address:** _____@_____

**Preferred method of communication for patient reminders** (Circle one): Email / Phone / Mail

**DOB:** __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

**Smoking Status (Circle one):** Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

*CMS requires providers to report both race and ethnicity*

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**Race (Circle one):** American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

**Ethnicity (Circle one):** Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

**Are you currently taking any medications?** (Please include regularly used over the counter medications)

| Medication Name | Dosage and Frequency (i.e. 5mg once a day, etc.) |
|---|---|
| | |
| | |
| | |

**Do you have any medication allergies?**

| Medication Name | Reaction | Onset Date | A Additional Comments |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

***For office use only***

Height: _____ Weight:_____ Blood Pressure:_____ /_____