It's time to feel better!

Dr. Katherine Iacuone and Dr. Dave Iacuone want to thank you for choosing Desert Valley Chiropractic for your healthcare needs. We are excited that you have made the choice to join our practice and we are looking forward to helping you achieve greater health through chiropractic.

We always want to show our appreciation to those that refer their family and friends. Please take a moment and check the appropriate box below indicating how you were first introduced to our office:

- ❑ **Walk –In**
- ❑ **Local Advertisement**
- ❑ **Friend** ________________________________ Please specify name
- ❑ **Patient** ________________________________ Please specify name
- ❑ **Relative** ________________________________ Please specify name
- ❑ **Community Event** ________________________ Indicate where
- ❑ **Work Place Event** ________________________ Indicate where
- ❑ **Other** ________________________________

____

Please print your Name

____

Patient's signature

Thank you again for choosing Desert Valley Chiropractic as your healthcare facility!

Patient Health History

Today's Date [/ /] **Signature of Patient** ______________________

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name______________________ **Nick Name**______________________

Last Name ______________________ **Middle Name** ____________**Suffix** ________

Address 1 ____

Address 2 ____

City______________________ **State**__________ **Zip Code** ______________

Primary Phone ______________________**Secondary Phone** ______________________

Mobile Phone ____

Home email ______________________ **Work Email** ______________________

Which email address would you like us to use to communicate with you? *(check one)*
❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth __________ **Age** ___ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified
Marital Status *(check one)* ❑ Single ❑ Married ❑ Other
SSN ______________________
Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check one)*

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian/Alaskan Native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian or other Pacific Island
❑Samoan	❑ Guamanian or Chamorro	❑Other________	❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown
Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify
Preferred Language *(check one)*

❑ English	❑ Spanish	❑ American Sign Language	❑ Chinese	❑ French	❑ German
❑ Tagalog	❑ Vietnamese	❑ Italian	❑ Korean	❑ Russian	❑ Polish
❑ Arabic	❑ Portuguese	❑ Japanese	❑ French Creole	❑ Greek	❑ Hindi
❑ Persian	❑ Urdu	❑ Gujarati	❑ Armenian	❑ I choose not to specify	

Verification Question *(choose only one question by circling the question, then give the answer to that question, **must be 6 characters or more**)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend? ❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up? ❑ What was the make of your first car? ❑ What is your favorite color?

Verification Answer to the Chosen question: ______________________________

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke:❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

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

No interest *Very Interested*

Current medications, including dosage if known.

If there are no current medications, check here: ❑

1) ______________________ **5)** ______________________
2) ______________________ **6)** ______________________
3) ______________________ **7)** ______________________
4) ______________________ **8)** ______________________

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1) ______________________ **3)** ______________________
2) ______________________ **4)** ______________________

Briefly list your main health problems: ______________________________

____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes❑ No If yes, describe: _

____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes❑ No If yes, what kind?

❑ Type I ❑ Type II - ***If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%?***

❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: ______________________________

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days?

❑ Yes ❑ No

Height: ______inches **Weight:** ___________ pounds **BP:** _______ / ________

Is this injury or illness work-related? Y N
If yes have you reported it to your employer? ____

Is this injury or illness related to an automobile accident? Y N
If yes, Name of :

Auto Ins. Co. ____ Policy # _____________________________

Agent's Name_______________________________ Agent's Phone # ______________________________

Address:____

City ______________________________________ State _____________ Zip Code _________________

Claim # _________________________________

Primary Care Physician

Name____

Address____

May we contact your PCP? Yes ☐ No ☐

Major Medical Insurance

Primary

____

Group#____ID_______________________________________

Secondary

____

Group#____ID#____________________________________

List an emergency contact and phone number:

____

HIPPA

By my signature below I acknowledge that I have received a copy of Desert Valley Chiropractic's HIPPA policy, and I am aware that there is a permanent copy posted in the waiting area.

Patient Signature ________________________________ Date ______________________________

AUTHORIZATION TO RELEASE INFORMATION

To: Dr. Katherine Iacuone
You are authorized to release any information you deem appropriate 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 of professional services rendered by you, and I hereby release you of any consequence thereof. This agreement will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original.

Medicare Patients

I request that payment of authorized Medicare benefits be made to me or on my behalf to Desert Valley Chiropractic for any services furnished to me Katherine Iacuone, D.C. I authorize that any holder of medical records about me to release to the Health Care Financing Administration and its agents any information necessary to determine benefits and process the insurance claim.

Non-Medicare Patients

In consideration of services to be rendered, I hereby assign and transfer to Desert Valley Chiropractic any benefits payable to or for my benefit under hospitalization, sickness or accident insurance, and any other insurance coverage, to include major medical or P.I.P., Medpay for the payment of such services rendered. I agree to cooperate, aid and assist Desert Valley Chiropractic in procuring all possible insurance benefits including initiation and fulfillment of all policy provisions such insurance companies may require for payment.

I further assign and transfer to Desert Valley Chiropractic an interest in any cause of action I may have arising out of injuries directly or indirectly resulting in this period of treatment. This assignment includes insurance benefits occurring to me under uninsured motorist coverage.

I UNDERSTAND THAT IF MY INSURANCE COMPANY DENIES ANY CLAIMS FOR MY CARE THAT I WILL ASSUME FINANCIAL RESPONSIBILITY FOR ALL CHARGES. I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND IT.

Please note that a signature below is required in order to receive treatment, if you have any questions or concerns we would be happy to discuss them with you.

Patient Signature:

____ ______________________________

(If patient is a minor, a parent's signature is required) (Responsible party)

Witness ____ Date ____________________________

CONSENT TO TREAT A MINOR CHILD:

Patient Name: ______________________________________ **Date: ____**

I hereby authorize this office to administer chiropractic as deemed necessary for my child.

Signature ___________________________________ (Parent/Legal Guardian) Date ___________________________________

I hereby authorize this office to treat my minor child without Parent/Guardian present at time of service.

Signature ___________________________________ (Parent/Legal Guardian) Date ____________________________________

Informed Consent

Health care is associated with some degree of risk for potential side-effects or unanticipated problems. We perform chiropractic adjustments with the Activator Instrument only, a low-force adjusting tool.

Chiropractic adjustments are the moving of bones to improve alignment and range of motion. The most serious problem associated with chiropractic adjustments is a stroke following adjusting of the neck in what is called the “extension-rotation-thrust” adjustment. We do not perform this adjustment!

Other possible complications include the following:

Soft tissue injuries, fracture of bones and injury to the intervertebral disc may occur with forceful adjustments. We do not perform these adjustments.

It is possible that you may develop very small areas of superficial bruising at the point of contact of the adjusting instrument on the skin, but this is minimal and goes away in a day or two. This is rare, but can happen in patients with fragile skin or those who are taking blood thinners.

Post-treatment soreness: There may be “soreness” following an adjustment. This is due to the muscles beginning to contract correctly again and the joints being re-aligned. It is similar to the soreness and stiffness one gets when they start exercising after a long period of no exercise. We have found that the patients who do develop soreness following the first treatment are the patients who usually heal the fastest.

We do not “twist, crack, or pop” your spine. The Activator Methods Technique of adjusting is a low-force and safe form of chiropractic adjusting.

By signing this form, you acknowledge that you are aware of these possible complications and agree to allow the doctor to adjust you with the Activator.

Date

Patient’s Signature

Patient Name: ____ **Date:** ____

Surgery (Please include all surgery)

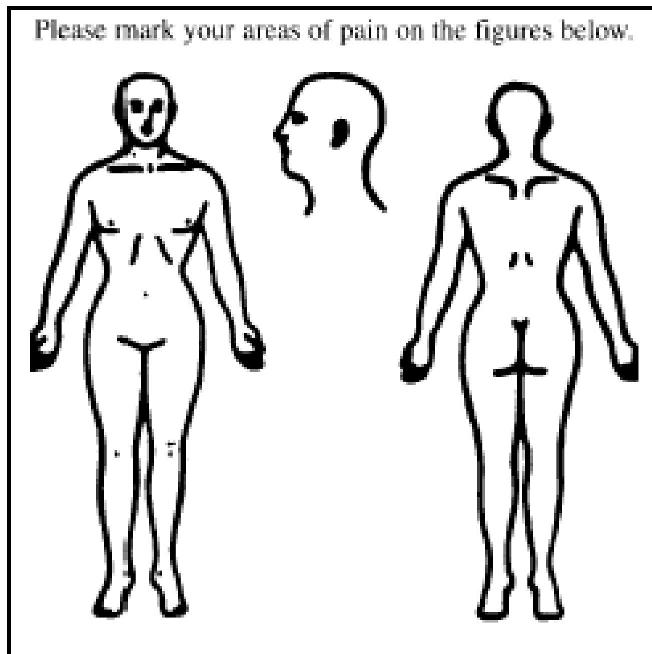
(1) Type____When___________________________

(2) Type____When___________________________

(3) Type____When___________________________

ARE YOU NOW OR HAVE YOU SUFFERED FROM ANY OF THE FOLLOWING:

☐Stroke	☐ Arthritis
☐Pacemaker	☐Numbness or pain in arms/legs/hands
☐ High blood pressure	☐Pain between shoulders
☐ Heart Attack	☐Swollen Joints
☐ Cancer	☐ Migraine
☐Heart disease	☐ Spinal curvature
☐ Diabetes	☐ Stiff Neck
☐Shingles	☐ Headache
☐Dizziness	☐Sinus Problems
☐ Pregnant at this time	☐Backache



0 ——————— 5 ——————— 10

Please rate your pain: 0 Absent -- 10 Extreme

What is your main area of concern____

On a Scale of 1-10 (10 being extreme pain) what is your pain level on **average**? ___________________

On a Scale of 1-10 (10 being extreme pain) what is your pain level at the **worst**? ____________________

Are symptoms: ◻ Getting Worse ◻ Getting Better ◻ Staying the same

How did the pain begin? ◻ Gradual ◻ Sudden

Please explain: ____

How long has pain been present? ____________________________

How often do your symptoms occur? Daily Weekly Monthly

Occasional (0–25%)____ Intermittent (25– 50%)_____ Frequent (50– 75%)_____ Constant (75– 100%)_____

When are your symptoms worst? Morning ______ Afternoon ______ Evening ______

Do your symptoms wake you up at night? Y N

Do your symptoms remain local? Y N

Do your symptoms radiate? Y N Left leg Right leg Left arm Right arm Back of head

Describe your symptoms? Dull ___ Sharp __ Burning___ Deep ___Ache __ Stabbing __ Tingling___ Other ________

Are your symptoms aggravated by: Sitting___Standing____Bending____Coughing____Sneezing___

Movement __ Straining ___ Reaching___ HouseChores____Other ____

Are your symptoms relieved by: Sitting___ Standing___ Lying____ Exercise____ Ice ___Rest ___ Heat ____

Stretching ____ Nothing ____ Other____