DESERT VALLEY CHIROPRACTIC

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:

❑ **Friend** _____ Please specify name

❑ **Patient** _____ Please specify name

❑ **Relative** _____ Please specify name

❑ **Online** ❑ **Google** ❑ **Yelp** ❑ **Zocdoc** ❑**Other**_____

❑ **Insurance company**_____

❑ **Walk –In**

❑ **Other** _____

_____
Please print your Name

_____
Patient's signature

Thank you again for choosing Desert Valley Chiropractic!

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 _____ **Mobile Phone** _____

Would you like to receive text Reminders? ❑ Yes ❑ No

Who is your cell phone carrier? _____

Email _____ **Can we leave a voicemail?** ❑ Yes ❑ No

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

Current medications, including dosage if known.

If there are no current medications, check here: ❑

1) _____ **4)** _____

2) _____ **5)** _____

3)_____**6)**_____

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 in the last 2 years?

❑ Yes ❑ No If yes, please explain: _____

Height: _____inches **Weight:** _____pounds **BP:** _____ / _____

Is this injury or illness related to an automobile accident? Y N

If yes, Name of: Auto Ins. Co. _____

Policy # _____ Claim # _____

Agent's Name_____ Agent's Phone # _____

Address: _____

City_____ State _____ Zip Code _____

Were you considered at fault? Y N

Is this injury or illness work-related? Y N

If yes have you reported it to your employer? _____

Primary Care Physician

Name_____

Address_____

May we send your initial note with diagnoses and care plan to your PCP? ❑ Yes ❑ No

Signature: _____

❑ **Major Medical Insurance** ❑ **Self- Pay**

Primary: _____

Group#_____ID_____

List an emergency contact and phone number:

_____

AUTHORIZATION TO RELEASE INFORMATION

To: Drs. Katherine and David 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 by Drs. Katherine and David Iacuone. 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 _____

Patient Name: _____ **Date:** _____

Surgery (Please include all surgery)

(1) Type_____When_____

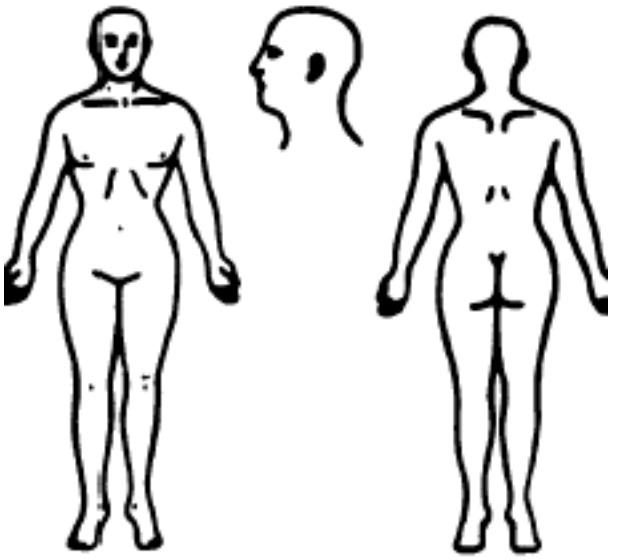
(2) Type_____When_____

(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

Please mark your areas of pain on the figures below.



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_____