

# Ferrigno Family Chiropractic, Inc.

## *Injury & Wellness Centers*

www.FerrignoChiropractic.com

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### PATIENT INTAKE FORM

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

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

Sex: M or F

Date of Birth: \_\_\_\_\_

Marital Status: S M D W

Age: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

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

Cell Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

SSN: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer/Occupation: \_\_\_\_\_

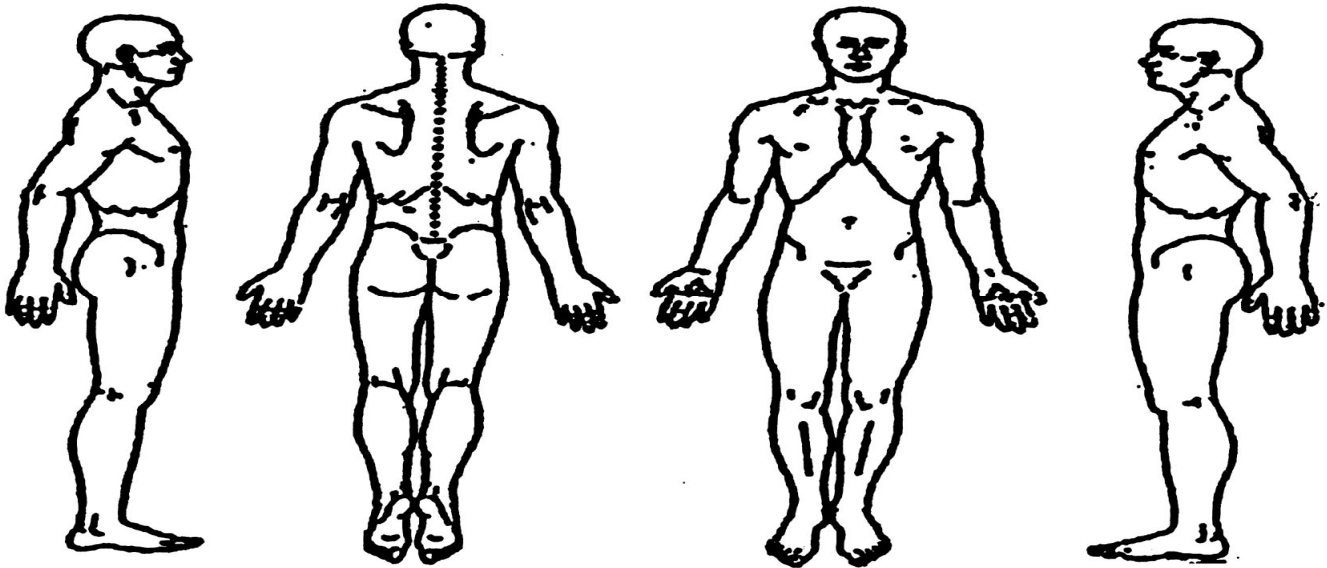
Work Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Contact Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Who do have to Thank for referring you to our office? \_\_\_\_\_

1. Is today's problem caused by:  Auto Accident  Workman's Compensation  Other \_\_\_\_\_

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

Constantly (76-100% of the time)

Frequently (51-75% of the time)

Occasionally (26-50% of the time)

Intermittently (1-25% of the time)

**4. How would you describe the type of pain?**

- Sharp
- Dull
- Diffuse
- Achy
- Burning
- Shooting
- Stiff
- Numb
- Tingly
- Sharp with motion
- Shooting with motion
- Stabbing with motion
- Electric like with motion
- Other: \_\_\_\_\_

**5. How are your symptoms changing with time?**

- Getting Worse
- Staying the Same
- Getting Better

**6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?**

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

**7. How much has the problem interfered with your work?**

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

**8. How much has the problem interfered with your social activities?**

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

**9. Who else have you seen for your problem?**

- Chiropractor
- ER physician
- Massage Therapist
- Neurologist
- Orthopedist
- Physical Therapist
- Primary Care Physician
- Other: \_\_\_\_\_
- No one

**10. How long have you had this problem? \_\_\_\_\_**

**11. How do you think your problem began?**

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**12. Do you consider this problem to be severe?**

- Yes
- Yes, at times
- No

**13. What aggravates your problem?**

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**14. What concerns you the most about your problem; what does it prevent you from doing?**

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**15. What is your: Height \_\_\_\_\_ Weight \_\_\_\_\_**

**16. How would you rate your overall Health?**

- Excellent
- Very Good
- Good
- Fair
- Poor

**17. What type of exercise do you do?**

- Strenuous
- Moderate
- Light
- None

**18. Indicate if you have any immediate family members with any of the following:**

- Rheumatoid Arthritis
- Heart Problems
- Diabetes
- Cancer
- Lupus
- ALS

**19. List all prescription medications you are currently taking:**

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**20. List all of the over-the-counter medications you are currently taking:**

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**21. List all surgical procedures you have had:**

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**22. What activities do you do at work?**

- Sit:
- Stand:
- Computer work:
- On the phone:
- Most of the day
- Most of the day
- Most of the day
- Most of the day
- Half the day
- Half the day
- Half the day
- Half of the day
- A little of the day
- A little of the day
- A little of the day
- A little of the day

23. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

<i>Past Present</i>	<i>Past Present</i>	<i>Past Present</i>
<input type="checkbox"/> Headaches	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/> Stroke	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Angina	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Allergies
<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/> Depression
<input type="checkbox"/> Wrist Pain	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/> Hand Pain	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Hip Pain	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Knee Pain	<input type="checkbox"/> Abnormal Weight Gain/Loss	
<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/> Loss of Appetite	<b><u>For Females Only</u></b>
<input type="checkbox"/> Jaw Pain	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Liver/Gall Bladder Disorder	
<input type="checkbox"/> Cancer	<input type="checkbox"/> General Fatigue	
<input type="checkbox"/> Tumor	<input type="checkbox"/> Muscular Incoordination	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Visual Disturbances	
<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Dizziness	
<input type="checkbox"/> Other: _____		

24. What activities do you do outside of work?

25. Have you ever been hospitalized?  No  Yes  
If yes, why \_\_\_\_\_

26. Have you had significant past trauma?  No  Yes

27. Anything else pertinent to your visit today? \_\_\_\_\_

28. May we provide your Physician with detailed reports regarding your care in this office?  No  Yes

Name of Physician \_\_\_\_\_ Mailing Address \_\_\_\_\_  
Phone \_\_\_\_\_

**Authorization, Consents, Financial Policy**

\*I authorize the Doctors to examine me and perform x-rays, if necessary. I also authorize the doctors to administer such treatment as is necessary, which may include Chiropractic adjustments and such additional therapies and procedures considered necessary on the basis of findings during the course of treatment.

\*I authorize Ferrigno Family Chiropractic, Inc. to release any information deemed 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 provided. I hereby release him/her of any consequence thereof. I hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services provided.

\*I agree to pay for services rendered as the charge is incurred. I understand that insurance policies are an arrangement between the carrier and myself and that I am personally responsible for payment of any and all services covered or non-covered. The policy deductible, co-pay, and/or co-insurance will apply and be my full responsibility. Payment plans will be handled on an individual basis. I understand that a \$30 fee will apply to all returned checks. I agree that a photocopy of this entire agreement shall be considered as effective and valid as the original.

I understand that payment is expected at time of service. I choose to pay by:

\_\_\_\_\_ CASH \_\_\_\_\_ CHECK \_\_\_\_\_ CREDIT CARD (VISA/MC/DISCOVER)

Patient (Parent or Guardian's) Signature \_\_\_\_\_ Date: \_\_\_\_\_

**CONSENT TO CARE**

A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physician.

I have read and understand the foregoing.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

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**X-RAY QUESTIONNAIRE: FOR WOMEN ONLY**

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

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

- There is a possibility that I may be pregnant at this time.
  - Yes. I am definitely pregnant
  - No. I am definitely not pregnant at this time
  - I request that x-ray films not be taken because \_\_\_\_\_
- 

**Date of last menstrual period:** \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

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**Consent to Treatment of Minor**

I/We, the undersigned, parent(s)/person having legal custody/legal guardianship of \_\_\_\_\_, a minor, do hereby authorize \_\_\_\_\_ as agent for the undersigned to consent to any x-ray examination and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general or special supervision of a licensed chiropractor.

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above described agent to give specific consent to any and all such diagnosis and treatment which chiropractor, meeting the requirements of this authorization, may, in the interest of his/her best judgment, deem advisable.

This authorization will remain effective until revoked in writing delivered to the agent noted above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_