

Ferrigno Family Chiropractic, Inc.

Injury & Wellness Centers

www.FerrignoChiropractic.com

Florence Office

2554 West Palmetto St.
Florence, SC 29501
843.662.2110
843.662.1991 Fax



Cheraw Office

1216 Chesterfield Hwy.
Cheraw, SC 29520
843.537.4100
843.537.6474 Fax

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: _____

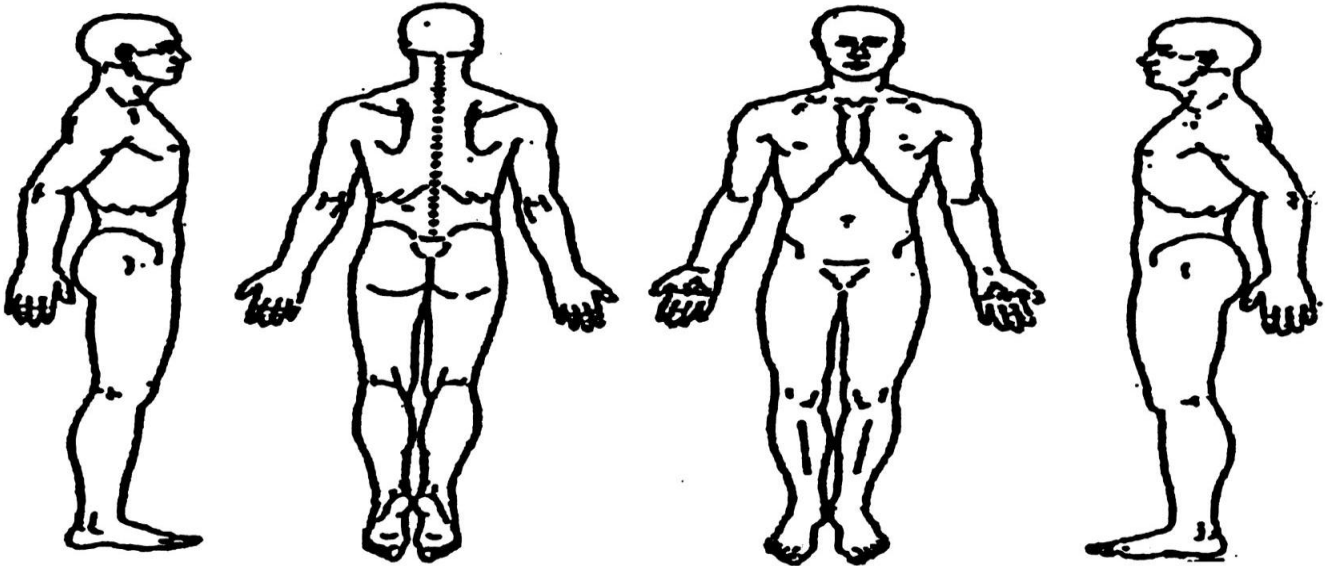
Work Phone: () ____ - ____

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?

12. Do you consider this problem to be severe?

- Yes
- Yes, at times
- No

13. What aggravates your problem?

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

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:

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

21. List all surgical procedures you have had:

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

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

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: _____

How We Protect Your Private Health Information

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe that the information may identify me.

I consent to the use or disclosure of my protected health information by this office for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of this office. I understand that **Dr. Mike Ferrigno** may refuse to diagnose or treat me, if I do not consent to the use or disclosure of my protected health information for the above states purposes. My signature on this document is evidence of this consent.

I understand I have a right to request a restriction as to how my personal health information is used or disclosed to carry out treatment, payment or health care operations at the practice. This office is not required to agree to the restrictions that I may request. However, if this office agrees to a restriction that I request, the restriction is binding.

I understand I have a right to review this office's Notice of Privacy practices prior to signing this document. This office's Notice of Privacy has been provided to me. This Notice of Privacy Practices describes the type of uses and disclosures of my protected health care information that will occur in my treatment, payment of my bills or in the performance of health care operations of this office. The Notice of Privacy Practices for this office is also provided upon request at the main administrative desk of this office. Notice of Privacy Practices also describes my rights and this office's duties with respect to my protected health information.

This office has the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by contacting the Privacy Officer at **843-662-2110 or 843-537-4100** and requesting a hard copy to be sent in the mail or by asking for one at the time of my next appointment.

I have the right to revoke this consent, in writing, except to the extent that this office or **Dr. Mike Ferrigno** has taken action in reliance on this consent.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions regarding the Privacy Policies, and all my questions have been answered fully and satisfactorily.

Patient Printed Name

Patient Signature

Date

Witness Printed Name

Witness Signature

Date

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Informed Consent to Treatment

The nature of chiropractic treatment: The doctor may use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic laser, acupuncture or mechanical traction may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment. I am here solely for the purpose of my health, and I represent no other agency, group, organization other than myself.

Patient Printed Name

Patient Signature

Date

Witness Printed Name

Witness Signature

Date