Ferrigno Healthcare

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: _____

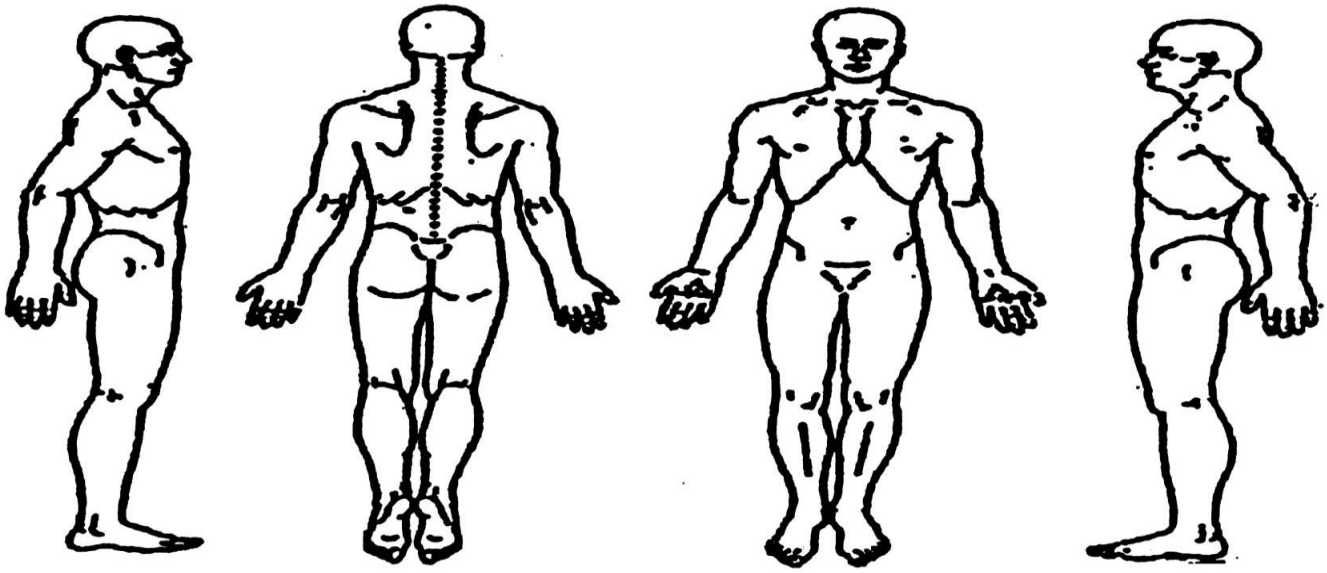
Work Phone: ( )_____-_____

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) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp	□ Numb
□ Dull	□ Tingly
□ Diffuse	□ Sharp with motion
□ Achy	□ Shooting with motion
□ Burning	□ Stabbing with motion
□ Shooting	□ Electric like with motion
□ Stiff	□ 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	□ Neurologist	□ Primary Care Physician
□ ER physician	□ Orthopedist	□ Other:_____
□ Massage Therapist	□ Physical Therapist	□ 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	□ Diabetes	□ Lupus
□ Heart Problems	□ Cancer	□ 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:	□ Most of the day	□ Half the day	□ A little of the day
□ Stand:	□ Most of the day	□ Half the day	□ A little of the day
□ Computer work:	□ Most of the day	□ Half the day	□ A little of the day
□ On the phone:	□ Most of the day	□ Half 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.

Past	*Present*		*Past*	*Present*		*Past*	*Present*	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Low Back Pain	□	□	Angina	□	□	Drug/Alcohol Dependance
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders	□	□	Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	Dermatitis/Eczema/Rash
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Abnormal Weight Gain/Loss			
□	□	Ankle/Foot Pain	□	□	Loss of Appetite	**For Females Only**		
□	□	Jaw Pain	□	□	Abdominal Pain	□	□	Birth Control Pills
□	□	Joint Pain/Stiffness	□	□	Ulcer	□	□	Hormonal Replacement
□	□	Arthritis	□	□	Hepatitis	□	□	Pregnancy
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder			
□	□	Cancer	□	□	General Fatigue			
□	□	Tumor	□	□	Muscular Incoordination			
□	□	Asthma	□	□	Visual Disturbances			
□	□	Chronic Sinusitis	□	□	Dizziness			
□	□	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 primary healthcare provider with detailed reports regarding you care in this office? No Yes

Name of Doctor _____ **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. dba Ferrigno Healthcare 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 herby 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 _____

FERRIGNO HEALTHCARE
2554 West Palmetto Street
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(843) 662-2110

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Ferrigno Healthcare or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. _____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date