Richard De Carlo
Doctor of Chiropractic

CASE HISTORY

DATE _____

NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ SOCIAL SECURITY NO. _____

HOME PHONE _____ WORK PHONE _____ MARITAL STATUS _____

SPOUSE'S NAME _____

CHILDREN'S NAMES AND AGES _____

_____

NAME OF EMPLOYER _____ OCCUPATION _____

HOW LONG EMPLOYED _____ WHO REFERRED YOU _____

_____

PLEASE DESCRIBE YOUR MAJOR COMPLAINTS AND SYMPTOMS _____

_____

_____

WERE THEY CAUSED BY A STRAIN? ____ STRESS? ____ FALL? ____ OVERUSE? ____

EXERCISE? ____ WORK RELATED? ____ AUTO ACCIDENT? ____ UNKNOWN? ____

WHEN DID THIS OCCUR? _____ REOCCURRING CONDITION? _____

ANY FAMILY HISTORY OF THIS CONDITION? _____

HAVE YOU BEEN TREATED BY ANOTHER DOCTOR FOR THIS CONDITION? _____

M.D. ____ D.O. ____ D.C. ____ NAME OF DOCTOR _____

DIAGNOSIS _____ TREATMENT _____

WERE X-RAYS TAKEN? _____ WHEN? _____ LENGTH OF TIME UNDER HIS/HER CARE? _____

RESULTS _____

_____

WHAT ACCIDENTS/FRACTURES HAVE YOU HAD? (INCLUDE DATES) _____

_____

WHAT MAJOR SURGERY HAVE YOU HAD? (INCLUDE DATES) _____

_____

LIST ANY MEDICATIONS YOU ARE PRESENTLY TAKING _____

WITHIN THE LAST 6 MONTHS? _____

_____

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect a thorough diagnosis, treatment plan and possibility of being accepted for care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Appendicitis
- ☐ Scarlet Fever
- ☐ Diptheria
- ☐ Typhoid Fever
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Malaria
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Goiter
- ☐ Influenza
- ☐ Pleurisy
- ☐ Alcoholism
- ☐ Venereal Infection
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorder
- ☐ Eczema
- ☐ Stroke or family history of

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Swollen Joints/Stiffness
- ☐ Walking Problems
- ☐ Difficulty Chewing
- ☐ Clicking Jaw

NERVOUS SYSTEM

- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities

GASTRO-INTESTINAL

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Trouble
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY

- ☐ Painful/Excessive Urination
- ☐ Discolored Urine
- ☐ Inability to Control Urination

C.V.R.

- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ Cardiovascular Disease
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ High/Low Blood Pressure
- ☐ Chronic Coughing
- ☐ Difficulty Breathing
- ☐ Asthma
- ☐ Chronic Congestion

EENT

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

MALE / FEMALE

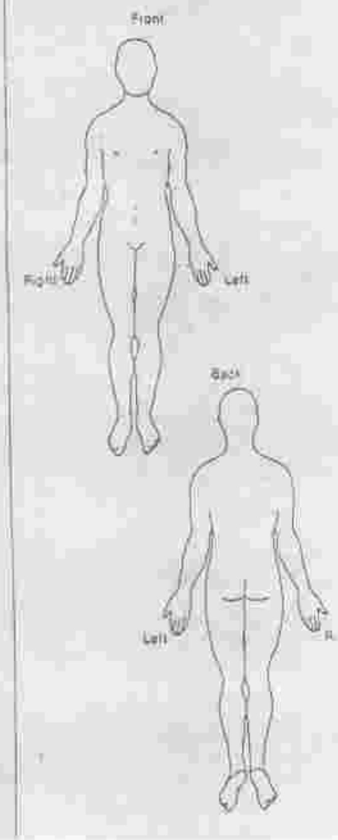
- ☐ Taking Oral Contraceptives
- ☐ Previous Miscarriage
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain/Infections
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Genital Herpes
- ☐ Are You Pregnant? ☐ No ☐ Yes ☐ Maybe
- ☐ When Was Your Last Period? ______________

GENERAL

- ☐ Allergies
- ☐ Sinus Problems
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Bruises Easily

Mark the areas on your body where you feel the described sensations. Use the appropriate symbols.

Ache · Burning · Numbness · Pins and Needles · Stabbing · Other



Patient's Signature ______________________________

Doctor's Signature ______________________________

NEUROLOGICAL AND VASCULAR PATIENT QUESTIONNAIRE

NAME _____ DATE _____

For any YES answer, please notify the Doctor:

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment: _____
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment: _____
3. Do your hands or arms fall asleep regularly? NO YES
   Comment: _____
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment: _____
5. Do you suffer from a loss of hand grip strength? NO YES
   Comment: _____
6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment: _____
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: _____
8. Do our legs or feet fall asleep regularly? NO YES
   Comment: _____
9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
   Comment: _____
10. Do you suffer from cold hands or feet? NO YES
    Comment: _____
11. Do you suffer from headaches, dizziness or memory loss? NO YES
    Comment: _____
12. Do you have difficulty maintaining your balance? NO YES
    Comment: _____
13. Do you suffer from vertigo or blurred vision? NO YES
    Comment: _____
14. Do you suffer from a reduced hearing capacity? NO YES
    Comment: _____
15. Do you suffer from ringing in your ears? NO YES
    Comment: _____
16. Do you haye bladder or bowel control problems on a regular basis? NO YES
    Comment: _____

DR. RICHARD DE CARLO

DOCTOR OF CHIROPRACTIC

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Office Policies for treatment, payment, and appointments

Initial

_____ I authorize De Carlo Family Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process a claim for reimbursement of charges incurred by me as a result of any consequences thereof.

_____ I hereby authorize and direct payment of any medical expense benefits allowable to Dr. De Carlo as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee.

_____ I fully understand and agree that insurance policies are an arrangement between the insurance carrier and myself. I will be responsible for any expenses not paid for by the insurance. Should I default, I agree to pay all cost of collection, including collection agency fees, court costs, and attorney fees.

_____ I acknowledge that Dr. De Carlo requires X-rays to be taken so a complete study and analysis may be made of my present problem or illness. I authorize and consent to Dr. De Carlo completing a radiographic examination and to administer whatever treatment is deemed necessary in order to treat my present problem or illness.

_____ To the best of my knowledge, I am NOT pregnant and Dr. De Carlo had my permission to X-ray me for diagnostic interpretation.

_____ Our office requires 24hour notice for cancellation of all appointments. If 24hour notice is not given, the patient will be charged a fee of $25 for the missed Chiropractic appointment and an $80 fee for the missed massage appointment. The patient is solely responsible as this can not be charged to insurance companies. We do understand emergencies arise and those cases will be under the discretion of our staff.

_____ It is the policy of this office to abide by any and all HIPPA requirements. If you would like a copy of this policy at any time, please ask our staff and one will be provided immediately.

_____ I agree that a photo static copy of this original shall serve as an original should verification be needed.

By initialing and signing this form, I certify that I, _____ have read, understood, and agree to abide by all of the above statements. (Print Name)

Patient Signature:_____ Date:_____

Witnessed By:_____ Date:_____

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Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§164.524).

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

X _____
Patient name printed

X _____
Date

X _____
Patient Signature

_____
Authorized Provider Representative

_____
Personal Representative Printed

_____
Personal Representative Signature

_____
Description of personal representative's authority to act for the patient.

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before your sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to it terms. I am also acknowledging that I have received a copy of this notice.

X _____ _____

Printed Name Authorized Provider Representative

X _____ _____

Signature Date

X _____

Date

DR. RICHARD DE CARLO

DOCTOR OF CHIROPRACTIC

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Please take a moment to fill in the following information:

How did you hear about our office?

- ☐ Shopping Center Sign
- ☐ Health Screening
- ☐ _____ insurance company
- ☐ Referred by _____

Have you ever had Chiropractic care?

_____

Please provide your email address below

_____

For your scheduling convenience, how would you prefer to be contacted?

- ☐ Text me at _____
- ☐ Call me at _____

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