LOMBINO
chiropractic and
nutritional wellness

126 Stage Road
Monroe, NY 10950
Tel. (845) 783-9797
Fax (845) 783-7935
www.drlombino.com

NEW CHIROPRACTIC PATIENT INTAKE FORM

Name_____ **Date**_____

Address_____ **Apt.#**_____

City _____ **State** _____ **Zip**_____

Home Phone (____) _____-_____ **Cell** (____) _____-_____ **Work** (____) _____-_____

WHICH NUMBER DO YOU PREFER TO BE CONTACTED ON (CIRCLE ONE)?

HOME CELL WORK

Date of Birth _____ **Age** _____ **Sex** M/F **Social Security #** _____

Marital Status S M D W **Name of Spouse/Parent** (***if patient is under 18***) _____

E-mail address _____

If you were referred by a patient, whom may we thank for referring you?

Name _____ **Address** _____

INSURANCE INFORMATION

Who is responsible for this account? _____ Relationship to Patient _____

Insurance Co. _____ Group # _____

Overall health (*circle one*) – Excellent / Good / Fair / Poor / Other: _____

Are you on any medications? If yes, please list _____

_____

WOMEN ONLY

Are you pregnant? *(Circle one)* Yes / No **Nursing?** *(Circle one)* Yes / No

Are you taking birth control pills? *(Circle one)* Yes / No

Do you smoke, drink coffee and/or alcohol? (*if yes indicate how much*)

Cigarettes _____ Coffee _____ Alcohol_____

List any major illnesses (***with approx. dates***)_____

_____

List any surgery or operations (***with approx. dates***) _____

_____

Past Accidents or injuries_____

_____

Any family history of serious illnesses (*circle those which apply*) Cancer / Diabetes / Heart Disease

Any additional information _____

Name: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS IN AS MUCH DETAIL AS YOU CAN:

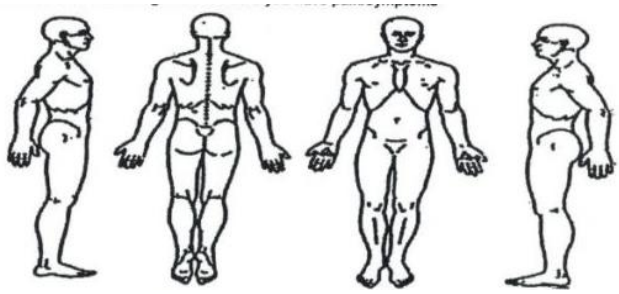
1. **Main Health Concern** (*reason you are here*) _____

_____

2. **How did this happen?** _____

_____

3. **Circle on the drawing where you have pain/symptoms…**



4. **Describe the site specifically** _____

5. **What percentage of the day do you feel the pain?**

❑ Intermittently (1-25%) ❑ Occasionally (26-50%)
❑ Frequently (51-75%) ❑ Constantly (76-100%)

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

❑ Sharp ❑ Sharp *(w/motion)* ❑ Achy ❑ Throbbing ❑ Shooting ❑ Shooting *(w/motion)*
❑ Numb ❑ Burning ❑ Tingling ❑ Stiffness ❑ Swelling ❑ Other _____

7. **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 (*Circle one*)

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

❑ Getting Worse ❑ Staying the Same ❑ Getting Better

9. **How long have you had this problem?** _____

10. **What makes the condition feel better?** _____

11. **What makes your condition feel worse?** _____

12. **Does the pain radiate out to your extremities?** Yes / No **If Yes, Where?** _____

13. **Does the pain occur during a specific time of day?** Yes / No **If Yes, When?** _____

14. **Which activities are difficult to perform?**

❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying down ❑ Other _____

15. **Have you had prior treatment for this condition?** Yes / No **Doctor Name:** _____

16. **Are you currently under another doctor's care?** Yes / No

Name of Doctor _____ **Specialty** _____

Address: _____ **Phone:** _____

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge and that the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic are to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group, insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of patient (or parent for a minor) ***Date***

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HIPPA CONSENT AUTHORIZATION

This notice is effective as of _____/_____/_____

I have read the Privacy Notice and understand my rights as contained in the notice.

By way of my signature, I provide Lombino Chiropractic & Nutritional Wellness with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operation as described in the Privacy Notice.

_____ _____

Patient's Signature Date

_____

Patient's Name (print)

_____ _____

Authorized Facility Signature Date

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Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed, but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporarily increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including, but not limited to, hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____Date: _____

Parent or Guardian: _____ Signature: _____Date: _____

Witness Name: _____ Signature: _____Date: _____