



**Dr. John Cianciolo** CHIROPRACTIC PHYSICIAN

t. 203-495-6800  
f. 203-495-6801

**TO THE NEW PATIENT**

**Welcome to our office.** Thank you for choosing us for your chiropractic needs. Our goal is to function as a team to provide our patients with personal attention and quality care. If you need assistance with this form, please do not hesitate to ask a staff member.

**Personal Data**

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

Gender:  Male  Female

Marital status:  Married  Single  Divorced

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

City: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Birth date: \_\_\_\_\_

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

Occupation: \_\_\_\_\_

Employer/School: \_\_\_\_\_

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

City: \_\_\_\_\_

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

Phone: \_\_\_\_\_

**Emergency Contact**

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

Phone: \_\_\_\_\_

**Method of Payment**

Please present insurance card(s) to the receptionist.

Cash

Attorney (if applicable)

Health Insurance (present card)

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

Company: \_\_\_\_\_

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

Worker Compensation

City: \_\_\_\_\_

Claim #: \_\_\_\_\_

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

Auto Related (present insurance card)

Phone: \_\_\_\_\_

Company: \_\_\_\_\_

Claim #: \_\_\_\_\_

**Medical History**

Have you had chiropractic care before?  Yes  No

Primary Care Physician's name: \_\_\_\_\_

Approximate date of your last physical \_\_\_\_\_

Are you currently under a physician's care for a particular condition?  Yes  No

If yes, state condition and treating doctor: \_\_\_\_\_

List any operations: \_\_\_\_\_

Are you on any medication?  Yes  No

Please notify the doctor of any condition for which you are taking medication,

including over-the-counter medication: \_\_\_\_\_

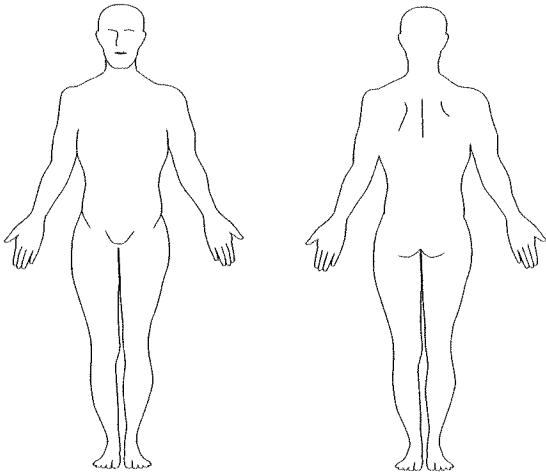
Do you have a pacemaker?  Yes  No If yes, please notify the doctor.

Please check any of the following symptoms you have now or have had within the past 3-6 months:

- |                                    |   |   |
|------------------------------------|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Inability to Control Bowel | <input type="checkbox"/> Constipation       |
| <input type="checkbox"/> Fever     | <input type="checkbox"/> Inability to Control Urine | <input type="checkbox"/> Chest Pain         |
| <input type="checkbox"/> Chills    | <input type="checkbox"/> Urinary Changes            | <input type="checkbox"/> Prostate Trouble   |
| <input type="checkbox"/> Sweaters  | <input type="checkbox"/> Diarrhea                   | <input type="checkbox"/> Frequent Urination |

**PAIN DRAWING**

Please indicate location of pain using the symbols noted below on this diagram:



- Sharp and Stabbing = ++++
- Dull and Achy = oooo
- Pins and Needles = vvvv
- Numbness = // // //

Please check any of the following diseases that you have now or have had:

- |  |                                    |   |
|--|------------------------------------|---|
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma             |
| <input type="checkbox"/> Tuberculosis  | <input type="checkbox"/> Stroke    | <input type="checkbox"/> Menstrual Problems |
| <input type="checkbox"/> Hypertension  | <input type="checkbox"/> Cancer    | <input type="checkbox"/> Other              |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Epilepsy  |   |

Location of type and pain (where does it hurt?) \_\_\_\_\_

How did this happen? \_\_\_\_\_

Have you suffered any recent falls or accidents? \_\_\_\_\_

If new accident or injury give date: \_\_\_\_\_

Have you lost any days from work? If so, please give details: \_\_\_\_\_

**For Women**

To the best of your knowledge, is there any chance you are pregnant?  Yes  No

If pregnancy is a possibility, please notify the doctor.

Date of last menstrual period \_\_\_\_\_

Please sign: \_\_\_\_\_

**PATIENT CONSENT**

Health Portability and Accountability Act of 1996 (HIPPA) requires our offices to obtain written patient consent forms before disclosing Protected Health Information (PHI). We respect the privacy of your health care information. Below is a list of circumstances in which we may have to use or disclose your health information.

- We may have to disclose your health information to other health care providers or hospitals for assessment, diagnosis, or treatment of your health condition.
- We have to disclose your health information and billing records to another party if they are potentially responsible for payment of services (i.e.; Insurance Co., Attorney, Third Party Liability).
- We may need to use your health information within our practice for quality control or operational purposes.

We have a HIPPA Office Log which provides a detailed description of how your health information may be use or disclosed. You have the right to limit uses or disclosures of your health information. You may also revoke your consent at any time in writing.

I have read your consent policy and agree to its terms.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Witness Signature