

500 Orange Street
New Haven, CT 06511

drcianciolo@aol.com



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: _____

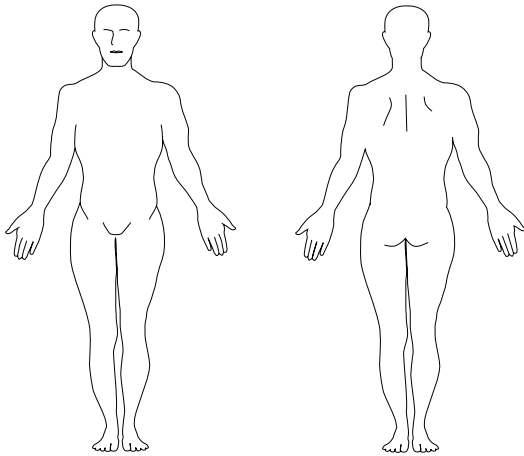
Do you have a pacemaker? Yes No If yes, please notify the doctor.

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