DeLanzo Chiropractic Center
701 West Ave, Suite 202 ▪ Ocean City, NJ 08226
Phone: (609) 399-4717 ▪ Fax: (609) 399-2561

Patient Health Assessment

Please PRINT or WRITE CLEARLY

Patient Name: _____ Today's Date: _____

Permanent Address: _____

City: _____ State: _____ Zip: _____

Summer Address (if different): _____

City: _____ State: _____ Zip: _____

Nickname: _____ Social Security #: _____

Home #: (_____) _____ Work #: (_____) _____ Cell #: (_____) _____

Preferred method of contact: □ Home □ Work □ Cell

Marital Status: _____ Date of Birth: _____ Patient Sex: □ M □ F

Email: _____

We will only use your email address to send appointment reminders. It will not be shared with any third parties.

Race: □ White □ African American □ American Indian □ Asian Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino

Patient Employer: _____ Occupation: _____

Primary Care Physician's Name/Number: _____

How did you find out about us? _____

Insurance Information

Insurance Company Name: _____

Subscriber Name: _____ Relation to Patient: _____

Subscriber Date of Birth: _____ Employer: _____

Subscriber Address: _____

Insurance ID#: _____ Group #: _____

Secondary Insurance Company Name (if applicable): _____

Subscriber Name: _____ Relation to Patient: _____

Subscriber Date of Birth: _____ Employer: _____

Subscriber Address: _____

Insurance ID#: _____ Group #: _____

Complaint History

1. Date pain/symptoms started ___ /___ /_____ *If ongoing issue, use date of most recent exacerbation.*
2. Describe how condition started: _____

_____

3. For EACH area you have pain, indicate side, pain level 0-10 (10 being severe) and all types that apply.

Neck Pain: □ Left □ Right □ Both Sides
0 1 2 3 4 5 6 7 8 9 10
□ Dull-achy □ Stiff □ Sharp □ Burning □ Numb

Mid Back: □ Left □ Right □ Both Sides
0 1 2 3 4 5 6 7 8 9 10
□ Dull-achy □ Stiff □ Sharp □ Burning □ Numb

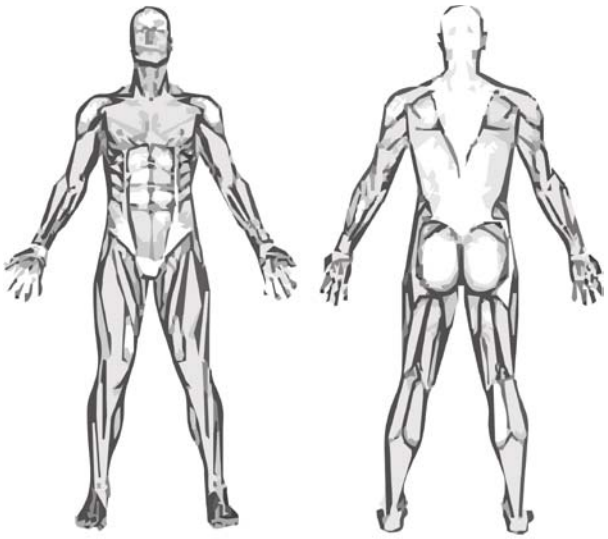
Low Back: □ Left □ Right □ Both Sides
0 1 2 3 4 5 6 7 8 9 10
□ Dull-achy □ Stiff □ Sharp □ Burning □ Numb

Buttocks/Sciatica: □ Left □ Right □ Both Sides
0 1 2 3 4 5 6 7 8 9 10
□ Dull-achy □ Stiff □ Sharp □ Burning □ Numb

Hip/Leg: □ Left □ Right □ Both Sides
0 1 2 3 4 5 6 7 8 9 10
□ Dull-achy □ Stiff □ Sharp □ Burning □ Numb

Shoulder/Arm: □ Left □ Right □ Both Sides
0 1 2 3 4 5 6 7 8 9 10
□ Dull-achy □ Stiff □ Sharp □ Burning □ Numb

Headaches: □ Left □ Right □ Both Sides
0 1 2 3 4 5 6 7 8 9 10
□ Dull-achy □ Stiff □ Sharp □ Burning □ Numb



4. <u>INDICATE WITH AN "X" ON DRAWING ABOVE WHERE YOU HAVE PAIN/SYMPTOMS</u>

5. How often is the pain present? □ Constant □ Frequent □ Occasional □ Intermittent
6. Since your problem began is the pain: □ Getting worse □ Getting better □ Staying the Same
7. How did your problem begin? □ Sudden □ Gradual □ Other type of accident: _____
8. What makes your problem better?
   □ Nothing □ Walking □ Standing □ Sitting □ Moving around/exercise □ Lying down □ Inactivity
9. What makes your problem worse?
   □ Nothing □ Walking □ Standing □ Sitting □ Moving around/exercise □ Lying down □ Inactivity
10. Were you previously treated for an earlier occurrence of this same condition? □ Yes □ No
    If yes, by whom? □ MD □ Chiropractor □ Physical Therapist □ Other _____

    What were the approximate dates, type of treatment and the results? _____

    _____

    Did you have x-rays taken? □ No □ Yes, where? _____
11. What is your physical activity at work?
    □ Mostly sitting □ Light manual labor □ Moderate manual labor □ Heavy manual labor
12. Do you exercise? □ No □ 1-2 times a week □ 3-4 times a week □ 5-7 times a week
    □ Cardiovascular □ Stretching □ Weight machine □ Free weights □ Sports _____(type)
13. What is your present general stress level?
    □ No stress □ Minimal stress □ Moderate stress □ Greatly stressed
14. Is your problem affecting your ability to work or do other routine daily activities?
    □ No effect □ Some limited physical restriction, but can function
    □ Need some assistance with daily activities □ Cannot work
    □ Cannot function without assistance □ Totally disabled

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Patient Name: _____

PLEASE CHECK ALL THAT APPLY TO YOU

ALLERGIES

□ Animals	□ Dairy Products	□ Latex	□ Rubber	□ Sulfa Drugs
□ Aspirin/Pain Meds	□ Dust	□ Molds	□ Seasonal Allergies	□ Wheat
□ Bee Sting	□ Eggs	□ Penicillin	□ Shellfish	□ X-Ray Dye
□ Chocolate/Sweets	□ Erythromycin	□ Ragweed/Pollen	□ Soaps	□ None

□ Other _____

SURGERIES

□ Ankle	□ Foot	□ Knee Replacement	□ Obstetrical	□ Urology
□ Appendix	□ Gallbladder	□ Lumbar Disc	□ Podiatric	□ Vasectomy
□ Back	□ Gastrointestinal	□ Lumpectomy	□ Prostate	□ Varicose Veins
□ Brain/Tumor	□ Gynecological	□ Lymph Node Biopsy	□ Shoulder	□ Wrist/Hand
□ Carpal Tunnel	□ Heart Bypass	□ Mastectomy	□ Thoracic Disc	□ None
□ Cervical Disc	□ Hernia	□ Neck	□ Tonsillectomy	
□ Elbow	□ Hip Replacement	□ Neurological	□ Thyroid	

□ Other _____

MEDICAL HISTORY

□ ADHD	□ Diabetes	□ Hand Pain	□ Kidney/Bladder Problem	□ Plantar Fasciitis
□ Ankle Pain	□ Digestive Problems	□ Headaches	□ Knee Pain	□ Prostate Problems
□ Arm Pain	□ Dizziness	□ Hearing Problems	□ Leg Pain	□ Respiratory Condition
□ Arthritis	□ Ehlers Danlos Syndrome	□ Heart Condition	□ Low Back Pain	□ Shoulder Pain
□ Asthma	□ Elbow Pain	□ Hepatitis	□ Lyme Disease	□ Sinus Condition
□ Back Pain	□ Epilepsy	□ High Blood Pressure	□ Menstrual Problems	□ Skin Condition
□ Broken Bones	□ Eye/Vision Problems	□ High Cholesterol	□ Migraine	□ Spinal Stenosis
□ Cancer	□ Fainting	□ Hip Pain	□ Multiple Sclerosis	□ Stroke/Heart Attack
□ Chest Pain	□ Fatigue	□ Hyperthyroidism	□ Neck Pain	□ Tumor
□ Concussions	□ Fibromyalgia	□ Hypothyroidism	□ Neurological Disorder	□ Weight Gain/Loss
□ Dementia	□ Foot Pain	□ Jaw Pain	□ Pacemaker	□ Wrist Pain
□ Depression	□ Gout	□ Joint Stiffness	□ Parkinson's Disease	□ None

□ Other _____

HABITS

Tobacco use: □ None □ Past □ Present □ Occasional □ Moderate □ Heavy

Alcohol use: □ None □ Past □ Present □ Occasional □ Moderate □ Heavy

Caffeine use: *(coffee, tea, soft drinks)* □ None □ Past □ Present □ Occasional □ Moderate □ Heavy

Pregnancy: □ N/A □ None □ Past □ Present Due Date _____

MEDICATIONS – PRINT CLEARLY	**Reason for Usage**

FAMILY HISTORY	**Condition**

Patient Signature: _____ Date: _____

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Patient Consent Form

Our Notice of Privacy Practices provides information about how we use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment and health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The Practice has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

Patient Signature: _____ Date: _____

Consent for Treatment

I, the undersigned, hereby authorize Dr. Ronald DeLanzo and whomever he may designate as his assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as necessary.

I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. HOWEVER, I CLEARLY UNDERSTAND AND SGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

Patient Signature: _____ Date: _____

Authorization to Release Medical Information

I authorize Dr. Ronald DeLanzo to release any medical information pertinent to my treatment plan to other medical providers that I deem necessary. This authorization for release of information shall remain valid unless I notify this office in writing. I certify that all insurance information given to this office is correct and complete. I also know that I am entitled to receive a copy of this authorization form.

Patient Signature: _____ Date: _____

Request for Payment of Benefits to Provider of Care

I hereby authorize my insurance company/insurance administrator to pay by check, and for it to be mailed directly to this office. The expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patient Signature: _____ Date: _____

Consent for Treatment of a Minor

I hereby authorize Dr. Ronald DeLanzo and whomever he may designate as his assistant(s), to perform diagnostic tests. Including, but not limited to radiographs, and to administer treatment as he deems necessary to my (relationship of child)_____, (child's name) _____.

Guardian's Signature: _____ Date: _____

X-Ray/Medical Release

I have requested the release of records of (patient's name) _____ which are part of the records at (facility) _____.

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by them, all copies of records and reports, including copies of x-rays and photostatic copies, abstracts or excerpts of all records and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future. Please forward this to (name) _____ (address)_____.

Patient Signature: _____ Date: _____