Today's Date:_____

Name:_____

Birth date: _____ Age: _____ ( ) Male ( ) Female

Address:_____

City:_____ State:_____ Zip: _____

Home Phone:_____ Cell Phone:_____ Text? ( )Yes ( )N Best Hours:_____

Email Address: _____

( ) Married ( ) Single ( ) Divorced ( )Widowed # of Children _____

Referred to our office by: _____ Relation:_____

Name of Emergency Contact:_____ Phone: _____

Employer:_____Occupation:_____

Is this visit a result of an accident? ( ) Yes ( ) No Work:____ Auto:____ Other:____

Health Insurance Information:

If you are in the office, you can present your card and skip section below

Primary Insurance Carrier:_____ ID#: _____

Policy Holder's Name_____ Group #: _____

Medical Release/Assignment of Benefits/Cancellation Policy

I authorize Amendola Family Chiropractic & Wellness, LLC to release any information necessary to process my claims for health care benefits. I agree to assign the benefits of my insurance carrier to Amendola Family Chiropractic & Wellness, LLC. I understand and that payments made directly to me from my insurance carrier for services rendered as an Out Of Network provider, are to be signed over to Amendola Family Chiropractic & Wellness, LLC. upon my receipt. I understand that I am fully responsible for any unpaid portion of charges incurred at this office. Regardless of insurance status, charges for services rendered are ultimately the patient's responsibility.

Patient's Signature _____ Date:_____

(Parent or Guardian if Minor)

General Health Information

Height _____ Weight _____ Left / Right Handed Do you have a pacemaker? ( )YES ( )NO

Have you ever received chiropractic care before? ( )YES ( )NO Dr's Name:_____

Have you undergone previous chiropractic or physical therapy in the past year? ( )YES ( )NO

List any diseases or health conditions you now have or have been treated for in the past.

_____

List any known allergies:_____

List any other trauma or injuries:_____

_____

List any hospitalizations or surgeries: _____

_____

Date of last physical: _____ Date of last Blood Test _____

Dr with these results:_____ XRAYS:_____ MRI'S:_____

Other tests:_____

Exercise: Type and Frequency: _____

Family History:

Check all that apply:

	Stroke	Heart Disease	Arthritis	Cancer	Diabetes	Other
Mother's Side	_____	_____	_____	_____	_____	_____
Father's Side	_____	_____	_____	_____	_____	_____

Current Symptoms

Reason for consulting Dr today: _____

_____

When did this pain or condition begin?:_____

Is your Pain: _____Sharp _____Dull _____Constant _____ Intermittent

Rate your pain on a scale from 0-10 (0=No Pain, 10=Severe Pain) Please circle: 0 1 2 3 4 5 6 7 8 9 10

Does your pain radiate or move? Please describe:_____

_____

What aggravates your condition/pain?:_____

_____

What relieves you condition/pain?:_____

Is the condition/pain worse at certain times of day?

When?:_____

Activities that are limited due to your condition/pain?:_____

Is the condition/pain getting progressively worse?:_____

_____

Previous Doctors or Treatments:_____

_____

Any Home Remedies used:_____

_____

Have you ever had the same or similar condition before? Please

explain:_____

Check any of the following symptoms which you have now or have had in the past.

___ Headaches
___ Pins & Needles in Arms/Legs
___ Neck Pain
___ Numbness in Fingers/Toes
___ Back Pain
___ Feeling of Anxiety
___ Chest Pain
___ Irregular Heart Rate
___ Stiff Neck
___ Shortness of Breath/Asthma
___Ears Ringing/Buzzing

___ Tension/Irritability
___Sleeping Difficulties
___ High Blood Pressure
___Clench/Grind Teeth
___ Cold Sores/Fever
___Blisters
___ Dizziness/Vertigo
___Depression/S.A.D.
___ Alcoholism/Addictions
___ Eyes Sensitive to Light
___ Recent Unexplained Weight Loss

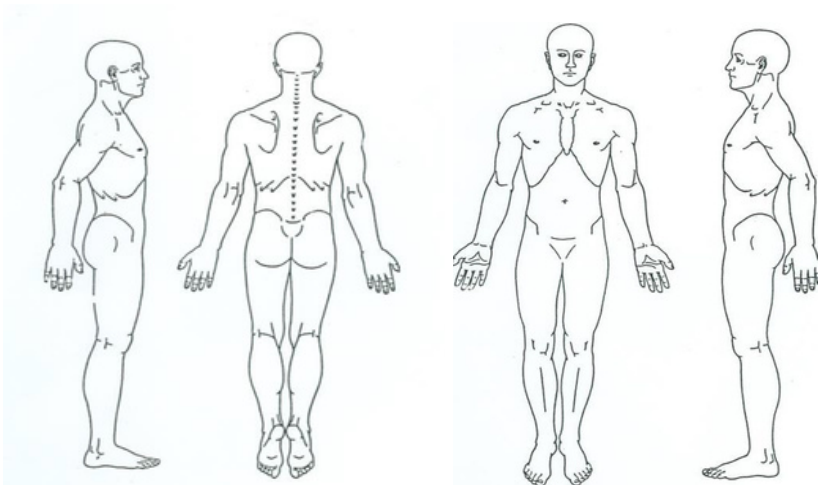
___ Cold Hands/Feet
___ Panic Attacks
___ Stomach upset/Ulcers
___ Irritable Bowel/Colitis
___ Leg/Feet cramps at night
___ Unexplained Fever
___ Eczema/Skin Rashes
__ Severe Menstural Cramps
___ Chronic Fatigue
___Roving Muscle/Joint Pain
___ Recent change in Bowel/ or bladder infection

Please list any medications you are prescribed and taking:

_____

_____

Please mark the diagrams with any of the following:



Numbness ----- **Pins & Needles 00000**

Burning XXXX **Stabbing //////**

Aching ++++ **Other ******

Please list any significant traumas or injuries you have had

_____

_____

_____

_____

Patients Signature: _____ Today's Date: _____

Acknowledgement of Receipt of this Notice

Amendola Family Chiropractic & Wellness, LLC is concerned about the privacy of our patient's health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgement, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

You may request a copy of Amendola Family Chiropractic & Wellness, LLC HIPPAA Notice of

Privacy Practices.

I acknowledge that I have received the Notice of Privacy Practices for: Amendola Family Chiropractic & Wellness, LLC.

Name of Patient (Print) _____

_____ _____

Signature of Patient or Authorized Representative Date

Consent To Contact

By supplying my phone number, email address and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system (ChiroTouch) to use personal limited information for the purpose of notifying me of pending appointment, a missed appointment, lab results or other communications.

 My signature indicates consent to be contacted by text message or email

 I choose to decline digital contact.

_____ _____

Signature of Patient or Authorized Representative Date

Financial Policy

If for any reason your account goes to our collection agency, all courtesy adjustments or discounts applied to your account will be removed. Attorney fees of 1/3 your total balance plus any processing fees that may be incurred will be added to your balance.

Patient Initials: _____

For subsequent visits, you may wish you keep your credit card on file for future payments. Please notify the front desk if you wish to keep your credit card on file.

Amendola Family Chiropractic & Wellness, LLC
Alan J. Amendola, DC

500 Monroe Turnpike, Suite #10 ~ Monroe, CT 06468
Phone: (203) 590-3407
Email: amendolafamilychiro@gmail.com

INFORMED CONSENT TO TREAT

I hereby consent to the performance of chiropractic treatment, related modes of therapy and/or massage therapy, on me (or the patient named below, for whom I am legally responsible) by the doctors of chiropractic and/or licensed massage therapists employed by Amendola Family Chiropractic & Wellness (Alan J. Amendola, DC). I understand that those doctors and massage therapists are providing services within their scope of practice as defined by the State of Connecticut.

I have had an opportunity to discuss with clinic personnel the nature and purpose of chiropractic procedures and/or massage therapy, and understand that results are not guaranteed.

I understand that, as in the practice of medicine, in the practice of chiropractic and/or massage therapy there are some risks to treatments, including but not limited to: fractures, disc injuries, dislocations and sprains. I do not expect the doctor/massage therapist to be able to anticipate and explain all risks and complications. I wish to rely on the doctor/massage therapist's judgment during the course of my treatment, based upon the facts then known, to provide therapies or procedures that he or she feels are in my best interests. As such, I understand that both my chiropractor and massage therapist must be made aware of any existing medical conditions, and that it is my responsibility to keep them updated on any changes to those conditions.

I have read the above noted consent and acknowledge that by signing this form, I confirm to consent to treatment and intend this consent to cover the treatment(s) discussed with me to deal with the physical condition for which I have sought treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I may seek treatment.

Patient Name: _____ Date:_____

Patient Signature: _____ Relationship: _____
(Or Patient Guardian/Representative)