Patient Information

NOLASCO CHIROPRACTIC, P.A.
5500 Bryson Drive, Suite 303, Naples, Fl. 34109
Phone: (239) 596-4244 Fax: (239) 596-4204

Name _____ Social Security #_____

Date of birth _____ Age _____ Height _____ Weight _____

Home address_____

City _____ State _____ Zip Code _____

Home phone _____ Cell phone _____Carrier _____

Email _____ Would you like email/text message _____

Occupation _____ Employer _____

Marital status: M S W D How many children _____

Spouse/Emergency contact name _____ Phone _____

Family medical doctor _____

Purpose of this appointment _____

Date symptoms appeared or accident happened _____

Have you ever had the same or a similar condition Yes No

If yes, when and describe_____

Prior surgeries _____

Prior injury/fractures _____

Past medical conditions _____

Past hospitalization _____

What medications are you taking _____

Please circle any and all insurance coverage that may be applicable in this case:
Major Medical Worker's Compensation Medicare Auto Accident Other

Name of primary insurance company _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature _____ Date_____

Guardian's Signature Authorizing Care _____ Date_____

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Name: _____ Date: _____

GENERAL
1 ___ Fever
2 ___ Chills
3 ___ Night Sweats
4 ___ Loss of Sleep
5 ___ Fatigue
6 ___ Nervousness
7 ___ Weight Loss or Gain
8 ___ Allergies
9 ___ Bleeding Problem
10 ___ Anemia
11 ___ Diabetes
12 ___ Cancer

EYE, EAR, NOSE, THROAT
13 ___ Change in Vision
14 ___ Pain in Eye(s)
15 ___ Deafness/Difficulty Hearing
16 ___ Nosebleeds
17 ___ Ringing in Ear
18 ___ Sinus Trouble
19 ___ Dental Problems
20 ___ Hoarseness
21 ___ Tonsillectomy

GASTROINTESTINAL
22 ___ Poor Appetite
23 ___ Poor Digestion
24 ___ Difficulty Swallowing
25 ___ Belching or Gas
26 ___ Frequent Nausea
28 ___ Vomiting Blood
30 ___ Ulcer
31 ___ Black or Bloody Stools
32 ___ Liver Problems
33 ___ Gall Bladder Problems
34 ___ Jaundice
35 ___ Hernia
39 ___ Appendicitis

WOMEN ONLY
40 ___ Live Births
42 ___ Painful Periods
44 ___ Irregular Cycles
46 ___ Hot Flashes

RESPIRATORY
50 ___ Difficulty Breathing
51 ___ Chronic Cough
53 ___ Spitting Blood
54 ___ Wheezing/Asthma
55 ___ Pneumonia
56 ___ Tuberculosis

CARDIOVASCULAR
57 ___ Irregular Heartbeat
58 ___ High Blood Pressure
59 ___ Heart Procedure
60 ___ Previous Heart Trouble
61 ___ Ankle Swelling
62 ___ Varicose Veins
63 ___ Rheumatic Fever
64 ___ Stroke

GENITOURINARY
65 ___ Frequent Urination
66 ___ Painful Urination
67 ___ Blood in Urine
68 ___ Kidney Disease
69 ___ Urinary Infection
70 ___ Inability to Control Urination
71 ___ Difficulty Starting Urine Flow
72 ___ Get up _____Times Per Night to Urinate
75 ___ Sexual Difficulties

SKIN
76 ___ Itching
77 ___ Bruising Easily
78 ___ Change in Mole(s)
79 ___ Skin Cancer

NEUROLOGIC
80 ___ Weakness
81 ___ Twitching
82 ___ Tremors
83 ___ Headache
84 ___ Fainting
85 ___ Dizziness
86 ___ Convulsions
87 ___ Epilepsy
88 ___ Numbness/Tingling
90 ___ Mental Disorder

MEN ONLY
91 ___ Testicular Swelling/Pain
92 ___ Prostate Problems

ACCIDENTS/TRAUMA
93 ___ Motor Vehicle Accidents
94 ___ Other Trauma/Accidents

MUSCULOSKELETAL
95 ___ Neck Stiffness/Pain
96 ___ Pain Between Shoulders
97 ___ Low Back Pain
98 ___ Arm/Leg Pain
99 ___ Painful Joints
100 ___ Muscle Aches/Soreness
101 ___ Spinal Curvature
102 ___ Arthritis
103 ___ Fractures/Broken Bones

HOSPITALIZATIONS
106 ___ List Dates and Reasons:

SURGERIES
107 ___ List Dates and Reasons

MEDICATIONS
108 ___ Prescription

109 ___ Non-Prescription

NUTRITIONAL STATUS
110 ___ Describe your nutritional status
poor, fair, good, excellent

111 ___ Vitamins :

112 ___ Herbs/Botanicals:

HABITS
113 ___ Smoking ____ packs a day
114 ___ Drinking
115 ___ Recreational Drug Use

EXERCISE
116 ___ None
117 ___ times a week

Family History
120 ___ Diabetes
121 ___ Thyroid Disease/Goiter
122 ___ Tuberculosis
123 ___ Kidney Disease
124 ___ High Blood Pressure
125 ___ Heart Disease
126 ___ Cancer
127 ___ Muscle, Bone or Nerve Disease
128 ___ Other

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Pain Drawing

Name:_____ Date:_____

TELL US WHERE YOU HURT.

Please read carefully:

Mark all the areas on your body where you feel your pain. If your pain radiates, draw an arrow from where it start to where it stops. Use the appropriate symbol(s) listed below.

Ache > > > > Numbness = = = = = Pins & Needles o o o o
Burning x x x x Stabbing / / / / Throbbing ~ ~ ~ ~ ~

Pain Scale

Please circle the number that best describes your pain

0 1 2 3 4 5 6 7 8 9 10

None Mild Moderate Severe