IMPASTATO CHIROPRACTIC NEW PATIENT HISTORY

Name: _____ Home Phone: _____

Home Address: _____ Cell Phone: _____ Work Phone: _____

City, State, Zip: _____ E-mail Address: _____

Birth Date: ____/_____/_____ (Age) _____ Social Security # _____/_____/_____ Gender: M F

Marital Status: S M D W Spouse's Name: _____ # of Children w/ Ages: _____

Occupation: _____ Employer Name: _____

Previous Chiropractic Care: Yes No Chiropractor's Name: _____ Last Visit: _____

Please check any health challenges you currently have or have experienced in the past 12 months:

__ Headache	__Feet/hands cold	__Head seems heavy	__Pins & needles in arms right/left
__Mental dullness	__Depression	__Confusion	__Pins & needles in hands right/left
__Loss of memory	__Constipation	__Dizzy	__Pins & needles in legs right/left
__Unbalanced	__Neck pain	__Neck stiffness	__Chest pain
__Rib pain	__Fainting	__Shortness of breath	__Ears ringing/buzzing
__Upper back pain	__Upper back stiffness	__Mid back pain	__Mid back stiffness
__Lower back pain	__Lower back stiffness	__Blurred vision	__Double vision
__Neck restriction	__Eye strain/pain	__Loss of taste	__Loss of smell
__Nervousness	__Fear	__Irritability	__Tension

Who may we thank for referring you to our office? _____ *Relationship:*_____

Name of primary care doctor? _____ Phone #:_____

Why are you seeking chiropractic care? _____

Briefly describe any health concerns: _____

Is this the result of an auto or work injury? _____ If so, when: _____

Does complaint (s) interfere with: ___Work ___Sleep ___Hobbies ___Daily Routine

Other doctors you have seen for this problem: _____

Spouse, parents, brother/sister, friends with similar health problems? _____

What are your health goals? _____

How do you expect to achieve these goals? _____

Have you been diagnosed with Cancer? Yes No

I attest that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or settlement. I authorize the release of any information to process my insurance claims and request payment directly to my health care practitioner.

Patient signature: _____ Date: _____

IMPASTATO CHIROPRACTIC
3440 DIVISION ST. STE G
METAIRIE, LA 70002
504/456-8560 FAX 504/456-8562

PATIENT HISTORY

Date: _____ Last year of School Completed: _____Ethnic Origin: _____

Name (Last) _____ (First) _____ M.I._____ Birth Date_____

ALLERGIES	ALLERGIC REACTIONS TO MEDICINE OR FOODS

Current Prescription Medications	Vitamin/Herbal Preparations	Over the Counter Medications

Tests & Immunizations (Indicate when and results)

Blood Profile _____
Breast Exam _____
Breast Mammography_____
Complete Blood Count_____
Chest X-Ray_____
Cholesterol/Triglycerides_____
Complete Physical_____
EKG_____
Enlarged Heart_____
Flu Shot_____
Genitalia Exam (Male)_____
Hearing Test_____
HIV Test _____
PAP Smear (Women)_____
Pneumonia_____
Pulmonary Function_____
Rectal Exam_____
Sigmoidscopy_____
Sodium & Potassium_____
Stool Occult Blood_____
Tetanus (DPT) _____
Treadmill Test_____
Urinalysis_____
Vision Test_____
Other_____

OPERATIONS

Tonsillectomy_____ Complications_____ Date_____
Appendectomy _____ Complications _____ Date_____
Hernia Repair _____ Complications_____ Date_____
Other _____ Complications_____ Date_____
Cholecystectomy_____ Complications_____ Date_____
Hysterectomy _____ Complications_____ Date_____
Other_____ Complications_____ Date_____
Radiation Therapy_____ Complications_____ Date_____

Name: _____ Date: _____

HOSPITALIZATIONS	Description	Hospital	Year
Illnesses (Kind)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Surgery (Kind)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Other (Reason)	_____	_____	_____

PERSONAL HABITS

Please answer honestly. This information is needed to assure the best possible treatment. All information is confidential. Please rate your answer on a scale of 1 to 5 (1= No/Never, 5 = Yes/Often).

	1	2	3	4	5	Elaborate
Exercise regularly						
Wear Seat Belts						
Use Illegal Drugs						
Drink Alcohol						
Smoke						
Chew or Dip Tobacco						
Experience Stress						
Other						

WOMEN ONLY **Menstrual Periods: Age of Onset_____ Regular?_____ Date Last Period Began_____**
Age Menopause _____ Difficulty with Periods? ___Yes ___No Specify_____
Number of Children: Born Alive_____ Cesarean_____ Stillborn_____ Miscarriages_____
Describe Complications:_____

Have you ever been referred to a specialist? ___Yes (Please Elaborate) ___No

_____
_____
_____

Have you ever been in an accident? ___Yes (Please Elaborate) ___No

_____
_____
_____

Are there any environmental risks involved in your job or home environment?__Yes (Please Elaborate) ___No

_____
_____
_____

MILITARY SERVICE

Which branch of service did you serve in? _____ Length of enlistment? _____ From_____ To_____
Did you sustain any injuries? ___Yes (Please Elaborate) ___No

_____
_____
_____

PERSONAL AND FAMILY HISTORY

Number of Brothers and Sisters_____

PERSONAL	YES	WHEN	YES	FAMILY SPECIFIC MEMBER
Abdominal Bleeding				
Allergies				
Anemia				
Arthritis				
Asthma/ Emphysema				
Back Disorders				
Bed Wetting				
Black Tarry Stools				
Bleeding Diseases				
Blood in Stool				
Blood in Urine				
Cancer				
Change in Bowel Habits				
Chest Pain				
Colitis				
Constipation				
Cough				
Coughing Blood				
Depression				
Diabetes				
Diarrhea				
Difficulty Swallowing				
Dizziness				
Enlarged Heart				
Double Vision				
Epilepsy				
Fainting Spells				
Gallstones				
Gall Bladder Disorder				
Glaucoma				
Headaches				
Heart Disease				
Heart Murmur				
Hepatitis				
Hoarseness				
High Blood Pressure				
Indigestion				
Irregular Heart Beat				
Kidney Infection				
Kidney Stone				
Leg Pain				
Lung Disease				
Lyme Disease				
Nosebleed				
Nervous Disorder				
Painful Urination				
Paralysis				
Phlebitis				
Pleurisy				
Pneumonia				
Pus in Urine				
Rheumatic Fever				
Stroke				
Swelling of feet				
Swollen/ Painful Joints				
T.B.				
Thyroid Disease				
Ulcer				

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PATIENT CONSENT

CONSENT FOR TREATMENT:

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedure. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physicians.

RELEASE OF INFORMATION:

By signing this form, you are granting consent to Impastato Chiropractic to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at 504/456-8560. You have a right to request us to explain how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

MEDICARE AND MEDICAID CONSENTY TO RELEASE INFORMATION:

I certify that the information given by me in applying for payment under Title XVII and/ or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to relay to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

VERIFICATION OF NON-PREGNANCY (Female Patients Only):

By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

_____
Print Patient's Name

_____
Patient's Signature

_____
Other Than Patient, Print Name & Relationship

_____
Witness

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NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal information is important to us. This notice describes how information about you may be used and disclosed and you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

You may inspect and receive copies of your records within 30 days a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

In the future, we may contact the Chiropractic Association of Louisiana for assistance in receiving reimbursement for your services when the party responsible for reimbursing your services has improperly processed your claim.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

Patient's Signature: _____Phone:_____

Authorized Provider Representative:_____ Date:_____

The effective date of this Notice of Information Practices is _____.

Thank you.