



WELCOME

PATIENT INFORMATION

TODAY'S DATE _____

PATIENT: _____

ADDRESS: _____

City _____ State _____ Zip _____

SEX: M F BIRTHDATE: _____ AGE _____

SINGLE MARRIED WIDOWED DIVORCED

PATIENT' SS# _____

OCCUPATION _____

EMPLOYER _____

EMPLOYER ADDRESS _____

SPOUSE'S NAME _____

BIRTHDATE _____

WHO MAY WE THANK FOR REFFERING YOU? _____

CONTACT INFORMATION

HOME _____ CELL _____

OTHER _____

BEST TIME TO REACH YOU _____

EMAIL _____

ARE YOU ON FACEBOOK? _____

IN CASE OF EMERGENCY, CONTACT:

NAME _____

RELATIONSHIP _____

PHONE# _____

INSURANCE INFORMATION

SUBSCRIBER'S NAME _____

RELATIONSHIP TO PATIENT _____

INSURANCE CO. _____

GROUP # _____

IS PATIENT COVERED BY ADDITIONAL INS? YES NO

SUBSCRIBER NAME _____

BIRTHDATE _____ SS# _____

RELATIONSHIP TO PATIENT _____

INSURANCE CO. _____

GROUP # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Colavito all insurance benefits, if any, otherwise payable to all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible party signature

Relationship _____ Date _____

ACCIDENT INFORMATION

IS THIS CONDITION DUE TO AN ACCIDENT? _____

IF SO, DATE OF ACCIDENT _____

TYPE OF ACCIDENT: AUTO WORK HOME

OTHER _____

TO WHOM HAVE YOU MADE A REPORT?

AUTO INSURANCE WORKERS COMP OTHER _____

ATTORNEY'S NAME (if applicable) AND PHONE# _____

PATIENT CONDITION

REASON FOR VISIT _____

WHEN DID YOUR SYMPTOMS APPEAR? _____

IS THIS CONDITION GETTING PROGRESSIVELY WORSE? YES _____ NO _____

RATE THE SEVERITY OF YOUR PAIN ON A SCALE FROM 1(LEAST) TO 10(SEVERE) _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN

TYPE OF PAIN: SHARP DULL NUMBNESS ACHING
 SHOOTING BURNING TINGLING CRAMPS STIFFNESS
 SWELLING THROBBING OTHER _____

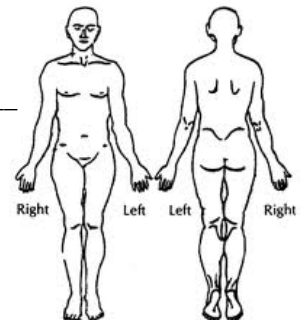
HOW OFTEN DO YOU HAVE THIS PAIN? _____

IS PAIN CONSTANT OR DOES IT COME AND GO? _____

DOES IT INTERFERE WITH YOUR WORK SLEEP DAILY ROUTINE RECREATION

ACTIVITIES OR MOVEMENTS THAT ARE PAINFUL TO PERFORM:

SITTING STANDING WALKING BENDING LYING DOWN OTHER _____



HEALTH HISTORY

WHAT TREATMENT HAVE YOU ALREADY RECEIVED FOR YOUR CONDITION?

- MEDICATIONS SURGERY PHYSICAL THERAPY CHIROPRACTIC SERVICES
 OTHER _____

NAME AND PHONE# OF THE DOCTOR(S) WHO TREATED YOU _____

DATE OF LAST: PHYSICAL EXAM _____ SPINAL X-RAY _____ BLOOD TEST _____
 SPINAL EXAM _____ CHEST X-RAY _____ URINE TEST _____
 DENTAL X-RAY _____ MRI,CT-SCAN,BONE SCAN _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? MARK AN X IN ALL THAT APPLY TO YOU:

- | | | |
|--|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> OSTEOPOROSIS |
| <input type="checkbox"/> ALCOHOLISM | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> PACEMAKER |
| <input type="checkbox"/> ALLERGY SHOTS | <input type="checkbox"/> FRACTURES | <input type="checkbox"/> PARKINSON'S DISEASE |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> GOITER | <input type="checkbox"/> PINCHED NERVE |
| <input type="checkbox"/> ANOREXIA | <input type="checkbox"/> GOUT | <input type="checkbox"/> PNEUMONIA |
| <input type="checkbox"/> APPENDICITIS | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> POLIO |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> PROSTATE PROBLEM |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> HERNIA | <input type="checkbox"/> PROSTHESIS |
| <input type="checkbox"/> BLEEDING | <input type="checkbox"/> HERNIATED DISK | <input type="checkbox"/> PSYCHIATRIC CARE |
| <input type="checkbox"/> DISORDERS | <input type="checkbox"/> HIGH CHOLESTEROL | <input type="checkbox"/> RHEUMATOID |
| <input type="checkbox"/> BREAST LUMP | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> ARTHRITIS |
| <input type="checkbox"/> BRONCHITIS | <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> BULIMIA | <input type="checkbox"/> MEASELS | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> MIGRAINE | <input type="checkbox"/> TONSILLITIS |
| <input type="checkbox"/> CHEMICAL | <input type="checkbox"/> HEADACHES | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> DEPENDENCY | <input type="checkbox"/> MISCARRIAGE | <input type="checkbox"/> TUMORS, GROWTHS |
| <input type="checkbox"/> CHICKEN POX | <input type="checkbox"/> MONONUCLEOSIS | |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> MULTIPLE SCLEROSIS | |

ARE YOU PREGNANT? YES, DUE DATE _____ NO

IS THERE ANY OTHER CONDITION, NOT MENTIONED ABOVE THAT THE DOCTOR SHOULD KNOW ABOUT?

ACTIVITIES OF DAILY LIVING

EXERCISE

- NONE
- MODERATE
- DAILY
- HEAVY

WORK ACTIVITY

- SITTING
- STANDING
- LIGHT LABOR
- HEAVY LABOR

HABITS

- SMOKING.....PACKS/DAY _____
- ALCOHOL.....DRINKS/WEEK _____
- COFFEE/CAFFEINE.....CUPS/DAY _____
- HIGH STRESS LEVEL.....REASON _____

INJURIES/SURGERIES YOU HAVE HAD

	<i>DESCRIPTION</i>	<i>DATE</i>
FALLS	_____	_____
HEAD INJURIES	_____	_____
BROKEN BONES	_____	_____
DISLOCATIONS	_____	_____
SURGERIES	_____	_____

MEDICATIONS

ALLERGIES

VITAMINS/HERBAL/MINERALS

