Name: ______________________________ Patient #: ______________________ Date: __________
Age ______ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed # of Children ________
Occupation ____
Reason for consulting our office? ____
____

YOUR HEALTH PROFILE

WHY THIS FORM IS IMPORTANT

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

THE BEGINNING YEARS

Research is showing that many of the health challenges that occur later in life have their origins during the development years, some starting at birth. Please answer the following questions to the best of your ability.

YOUR CHILDHOOD YEARS

	YES	NO	UNSURE	COMMENTS
Did you have any childhood illnesses?	☐	☐	☐	______________________
Did you have any serious falls as a child?	☐	☐	☐	______________________
Did you play youth sports?	☐	☐	☐	______________________
Did you take / use any drugs?	☐	☐	☐	______________________
Did you have any surgery?	☐	☐	☐	______________________
Have you fallen / jumped from a height over three feet? (i.e. – crib, bunk bed, trees)	☐	☐	☐	______________________
Were you involved in any car accidents as a child?	☐	☐	☐	______________________
Was there any prolonged use of medicine such as antibiotics or an inhaler?	☐	☐	☐	______________________
Did you suffer any other traumas (physical or emotional)	☐	☐	☐	______________________
Were you vaccinated?	☐	☐	☐	______________________
As a child, were you under regular Chiropractic care?	☐	☐	☐	______________________

ADULT – (18 to present)

	YES	NO	UNSURE	COMMENTS
Do / did you smoke?	☐	☐	☐	______________________
Do / did you drink alcohol?	☐	☐	☐	______________________
Have you been in any accidents?	☐	☐	☐	______________________
Have you had any surgery?	☐	☐	☐	______________________
Do / did you play any adult sports?	☐	☐	☐	______________________
Do / did you participate in extreme sports?	☐	☐	☐	______________________

On a scale of 1 – 10 describe your stress level:
(1 = none / 10 = Extreme)
Occupational ____________
Personal ____________

On a scale of Poor, Good, Excellent describe your:
Diet __________ Exercise __________ Sleep __________ General Health __________

Addressing The Issues That Brought You To The Office

If you have no symptoms or complaints, and are here for wellness services, please check (√) here ________ **"Wish to have Chiropractic Wellness Services"** and skip to **"Family Health Profile."** Others need to briefly describe the chief area of complaint, including the effect it has had on your life.

If you are experiencing pain, is it…

☐ Sharp ☐ Dull ☐ Comes and goes ☐ Travels ☐ Constant

Since the problem started, it is… ☐ About the same ☐ Getting better ☐ Getting worse

What makes it worse: ____

Yes, it interferes with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

Other Doctors seen for this problem (please list)

☐ Chiropractor ____
☐ Medical Doctor ____
☐ Other ____

Please check (√) all symptoms you have ever had, even if they do not seem related to your current problem.

Are You Pregnant? ☐ YES ☐ NO

☐ Headaches	☐ Pins and needles in legs	☐ Fainting	☐ Neck pain
☐ Pins and Needles in arms	☐ Loss of smell	☐ Back Pain	☐ Loss of Balance
☐ Dizziness	☐ Buzzing in Ears	☐ Ringing in Ears	☐ Nervousness
☐ Numbness in fingers	☐ Numbness in toes	☐ Loss of taste	☐ Stomach Upset
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension
☐ Sleeping problems	☐ Neck stiff	☐ Cold Hands	☐ Cold feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot Flashes
☐ Cold Sweats	☐ Lights bother eyes	☐ Problem Urinating	☐ Heartburn
☐ Mood swings	☐ Menstrual Pain	☐ Menstrual Irregularity	☐ Ulcers

List any medications you are taking ____
____

Family Health Profile:
At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children ____
Spouse ____
Mother ____
Father ____
Brothers ____
Sisters ____
Others ____

Have you ever:

Bought bottled water:	☐ **Yes**	☐ **No**	**When Last?** ________________
Belonged to a health club:	☐ **Yes**	☐ **No**	**When Last?** ________________
Consumed vitamins or supplements:	☐ **Yes**	☐ **No**	**When Last?** ________________

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:

______________________________ Signature ________________ Date

CONIGLIO CHIROPRACTIC & WELLNESS
1144 MANTUA PIKE
MANTUA, NJ 08051

PATIENT REGISTRATION

PATIENT'S NAME: ________________________________ PHONE #: ______________

CELL#:____________________ EMAIL:______________________________

ADDRESS: ____
(STREET) (CITY) (STATE) (ZIP)

SS #: ____________________ DATE OF BIRTH: ______________ AGE: ________

EMPLOYER: ________________________________ TELEPHONE: ______________

ADDRESS: ____
(STREET) (CITY) (STATE) (ZIP)

IN CASE OF EMERGENCY: ____________________________ PHONE #: ______________

LEGAL GUARDIAN (IF MINOR): ____

ADDRESS: ____
(STREET) (CITY) (STATE) (ZIP)

SS #: ____________________ DATE OF BIRTH: ______________ AGE: ________

EMPLOYER: ________________________________ TELEPHONE: ______________

WHO REFERRED YOU TO OUR OFFICE? ____________________________________
WOULD YOU BE INTERESTED IN REFERRING YOUR FAMILY MEMBERS? ________________
BILLING RESPONSIBILITIES:

INSURANCE COMPANY: ________________________ PHONE #: ______________

ID/CLAIM #: ______________________________ GROUP #: ______________

INSURED'S NAME: __________________________ SS #: ________________

INSURED'S DATE OF BIRTH: ____________________

CHIROPRACTIC BENEFITS ARE QUOTED TO US BY YOUR INSURANCE CARRIER. THE BENEFITS ARE SUBJECT TO THE TERMS AND PROVISIONS OF YOUR PLAN AND ARE NOT NECESSARILY A GUARANTEE OF PAYMENT.

1. I authorize my insurance benefits to be paid directly to Coniglio Chiropractic & Wellness.
2. I am financially responsible for any non-covered services.
3. I authorize the facility to release medical information for billing.

*SIGNATURE: ________________________________ DATE: ________________

OFFICE POLICY REGARDING INSURANCE ASSIGNMENT, SELF-PAYING AND APPOINTMENT SCHEDULING

Coniglio Chiropractic L.L.C. is pleased to accept your insurance assignment, as soon as the responsible party verifies your exact coverage. We will file forms to assist you in every way we can. It must be fully understood that the contract is between you and your insurance company. You are fully responsible for any amount that is not paid by your insurance.

1. You are required to sign an "Authorization to Pay Physician" form and any other assignment documents required by your insurance company on your first visit.
2. Our office does not guarantee that your insurance will pay. We will make every attempt, at the beginning of your health care, to receive verification of your policy and what it covers. However, if for some reason, your insurance claim is denied, you are responsible for the full amount.
3. Our office will ***NOT*** enter into a dispute with your insurance company over your claim. This is your responsibility and obligation. If circumstance warrants, your insurance assignment may be withdrawn.
4. You are required to pay the percentage of your responsibility as you go along. (E.g. if your insurance pays 80% of your care, you pay 20% on each visit).
5. Any insurance balance over 60 days past due is subject to late payment penalties at 1.5% per month.
6. I agree to pay any collection and/or attorney fees that may arise as a result of any unpaid balance being forwarded to a collection agency and/or attorney to cause payment.
7. All returned checks are subject to a $25 service fee and a late payment fee (see below).
8. A late payment fee will be assessed if payment on balance is not received by the 10th of the month.
9. Late Payment Fee: $15 if the balance is $0 - $99; $25 if the balance is $100 - $999.99; and $35 if the balance is $1000 or more. (Balance means Previous Balance on Statement that shows the Late Fee.)
10. A $30.00 fee will be charged if an appointment is missed without prior rescheduling.
11. For your health this is a Smoke-Free property.
12. I have read and understand the above office policy and agree to its terms.

_______________________________________ ____________

SIGNATURE OF PATIENT/GUARDINAN **DATE**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Coniglio Chiropractic L.L.C.
1144 Mantua Pike
Mantua, NJ 08051

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice Of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________________

Relationship to Patient: ______________________________

Signature: ______________________________

Date: ______________________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

December 2005

Coniglio Chiropractic L.L.C.

INFORMED CONSENT FORM

I hereby request and consent to the performance of chiropractic adjustments and other professional procedures, including various modes of physio-therapy, acupuncture and diagnostic services, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic and/or any other licensed professionals who now or in the future treat me while employed by, working or associated with, or serving as backup for the doctor named below, including those working at the office.

Chiropractic treatment involves the science, philosophy, and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use their hands or a mechanical device upon my body to adjust a joint, which may cause an audible “pop” or “click”. It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which they feel at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor’s interpretation thereof, as well as the doctor’s judgment and expertise in working with like cases.

This office includes nutritional recommendations in the treatment of patients. The goal of nutrition is to support the body to improve its overall health and not to treat a specific disease or symptom. All medication changes must be made by my medical physician. I understand nutritional supplements have been proven to be extremely safe when taken as directed. There is always a chance for an adverse reaction from any product. If I feel I am having a reaction to a product, I will stop using the product until I can discuss the matter. The products are sold retail and there is a NO refund policy.

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, and treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided.

I have had the opportunity to discuss with the doctor and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic, there are some risks of treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

I have read, or have had read to me, the Informed Consent to Professional Care. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

________________________________ Name (printed)

____________________ Date Signed

____
Signature: Patient or Legal Representative (Attorney, Guardian, Parent)

BC/sl-dts