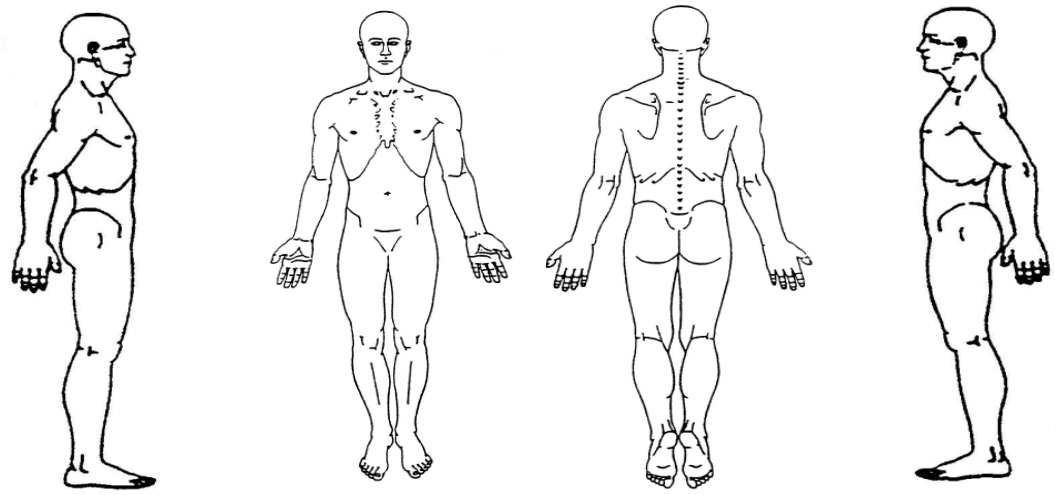
Please write legibly and fill out ALL information.

Name: _____ Date: _____

Address: _____ E-Mail: _____
_____ Phone #: _____
_____ Alt Phone #:_____
Birth Date: _____ Allow appointment reminders via text? YES or NO
Marital Status: _____ **IF YES, LIST CELL CARRIER**: _____
S.S #: _____ Emergency Contact Name: _____
Preferred method of contact: _____ & Phone #: _____

1. Is today's problem caused by:
□ Auto accident □ Work Related Injury □ Other _____

2. Indicate on the drawings below where you have pain/symptoms and how severe EACH problem is (using a scale of 0 – 10 where 10 is the worst):



3. Using a scale from 0 – 10 (10 being the worst), how would you rate each of your problems?
0 1 2 3 4 5 6 7 8 9 10

4. How often do you experience your problems?
□ Constantly (76-100% of the time) □ Frequently (51-75% of the time)
□ Occasionally (26-50% of the time) □ Intermittently (1-25% of the time)

5. How would you describe the type of pain for each problem?

□ Sharp	□ Shooting	□ Sharp with motion
□ Dull	□ Stiff	□ Shooting with motion
□ Diffuse	□ Numb	□ Stabbing with motion
□ Achy	□ Tingly	□ Stabbing with motion
□ Burning	□ Electric like with motion	□ Other _____

6. How are your symptoms changing with time? Please indicate for EACH symptom:
□ Getting worse □ Staying the same □ Getting better

7. How much has each problem interfered with your work?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Very much

8. How much has each problem interfered with your social activities?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Very much

9. Who else have you seen for your problem(s)?
□ Chiropractor □ Neurologist □ Primary care physician
□ ER Physician □ Orthopedist □ No one
□ Physical Therapist □ Massage Therapist □ Other _____

10. By whom were you referred? _____

11. Who is your primary care doctor? _____

12. Do we have your permission to send your primary care doctor reports? □ Yes □ No

13. Do you consider your problem(s) to be severe?
□ Yes □ Yes, at times □ No
If yes, which ones?
_____

14. How long have you had each problem?
_____

15. How do you think each problem began?
_____

16. What aggravates each of you problems?
_____

17. What alleviates (helps) each of you problems?
_____

18. What concerns you the most about each of your problems? What does it prevent you from doing?
_____

19. What is your: Height:_____ Weight: _____
Occupation: _____ Employer: _____

20. How would you rate your overall health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

21. What type of exercise do you do?
□ Strenuous □ Moderate □ Light □ None

22. Indicate if you have immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus □ Cancer □ Heart Problems □ ALS

23. For each of the conditions listed below, place a check or "x" in the past column if you have had the condition in the past. If you presently have a condition listed below, place a check or "x" in the present column.

Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure
□	□	Neck Pain	□	□	Heart Attack
□	□	Upper Back Pain	□	□	Chest Pains / Angina
□	□	Mid Back Pain	□	□	Stroke
□	□	Lower Back Pain	□	□	Kidney Stones
□	□	Shoulder Pain	□	□	Bladder Infection
□	□	Elbow/Upper Arm Pain	□	□	Painful Urination
□	□	Wrist Pain	□	□	Loss of Bladder Control
□	□	Hand Pain	□	□	Prostate Problems
□	□	Upper Leg Pain	□	□	Abnormal Weight Gain/Loss
□	□	Knee Pain	□	□	Loss of Appetite
□	□	Ankle/Foot Pain	□	□	Abdominal Pain
□	□	Jaw Pain	□	□	Ulcer
□	□	Joint Pain/Stiffness	□	□	Hepatitis
□	□	Arthritis	□	□	Liver/Gall Bladder Disorder
□	□	Rheumatoid Arthritis	□	□	General Fatigue
□	□	Cancer	□	□	Muscular Incoordination
□	□	Tumor	□	□	Visual Disturbances
□	□	Asthma	□	□	Dizziness
□	□	Chronic Sinusitis	□	□	Diabetes
□	□	Depression	□	□	Excessive Thirst
□	□	Systemic Lupus	□	□	Frequent Urination
□	□	Epilepsy	□	□	Smoking/Tobacco Use
□	□	Dermatitis/Eczema/Rash	□	□	Drug/Alcohol Dependence
□	□	HIV-AIDS	□	□	Allergies
□	□	Other_____			

For Women Only:

Past	Present		Past	Present	
□	□	Birth Control Pills	□	□	Hormonal Replacement
□	□	Pregnancy			

24. List all prescription medications you are currently taking: _____
_____

25. List all over the counter medications you are currently taking: _____
_____

26. List all surgical procedures you have had: _____
_____

27. What activities do you perform at work?

□ Sit	□ Most of the day	□ Half of the Day	□ A Little of the Day
□ Stand	□ Most of the day	□ Half of the Day	□ A Little of the Day
□ Computer Work	□ Most of the day	□ Half of the Day	□ A Little of the Day

□ Talk on the Phone	□ Most of the day	□ Half of the Day	□ A Little of the Day
□ Drive	□ Most of the day	□ Half of the Day	□ A Little of the Day
□ Manual Labor	□ Most of the day	□ Half of the Day	□ A Little of the Day
□ Read	□ Most of the day	□ Half of the Day	□ A Little of the Day

28. What activities do you do outside of work? _____
_____

29. Have you ever been hospitalized? □ No □ Yes
If so, why? _____

30. Have you seen a chiropractor before? □ No □ Yes
If so, who and when? _____

What were the results of your treatment?
□ Great □ Good □ Fair □ Mixed □ Poor □ Other _____

31. Have you had significant past trauma? □ No □ Yes
If yes, describe _____

32. Have you had a non-fasting cholesterol test in the last 5 years? □ No □ Yes
If yes, when? _____

33. Have you had an influenza vaccination this year? □ No □ Yes
If yes, when? _____

34. Have you been screened for colon cancer? □ No □ Yes
If yes, when? _____

FEMALES
35. Are you up to date on your PAP SMEARS? □ No □ Yes
If yes, when was the last? _____

MALES
36. Have you been screened for prostate problems? □ No □ Yes
If yes, when? _____

37. Is there any other information pertinent to your visit today? _____
_____
_____

Patient Signature: _____ Date: _____

CONTINO CHIROPRACTIC CENTER

DR. JEFFREY T. CONTINO, D.C.

CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

I, _____, authorize Dr. Jeffrey T. Contino to use and disclose my health and medical information for the purpose of treatment, payment, and health care operations.

Treatment: includes activities performed by a physician, nurse, office personnel and other types of healthcare professional providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my practice.

Payment: Includes activities involved in determine your eligibility for health plan coverage, billing, receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, precertification and preauthorization.

Health Care Operations: Includes the necessary administrative and business functions of our office.

You may review Contino Chiropractic Center's "*Notice of Privacy Practices*" for additional information about the uses and disclosures of information described in this *Consent* prior to signing. Please verify that received a copy of our *Notice* by placing your **initials** here: _____

Because we reserve the right to change our privacy practices in accordance with the law, the terms contained in this notice may change. We will offer you a copy of the new/updated *Notice* on your first visit to us after the effective date of such. We will also provide you with a copy of the *Notice* upon your request.

As more fully explained in the *Notice*, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operation purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide your emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with this *Notice*.

I understand that I have the right to revoke this consent provided that I do so <u>in writing</u>, except to the extent that Contino Chiropractic Center has already used or disclosed the information in reliance on this consent.

_____ _____

Patient Signature/Authorized Representative Date

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____

Patient S.S #: _____ Birth Date: _____

1. I authorize the use or disclosure of the above named individual's health information as described below:

2. The following individual or organization is authorized to make the disclosure:
   CONTINO CHIROPRACTIC CENTER

3. The type and amount of information to be used or disclosed is as follows:
   a. Problem list
   b. Medication list
   c. List of allergies
   d. Laboratory results
   e. X-Ray and imaging reports
   f. Consultation reports
   g. Entire Record
   h. Other: _____

4. I understand that the information in my health records may include information relating to a sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual(s) or organization(s):
   Jeffrey T. Contino, D.C
   Contino Chiropractic Center
   174 W. Commerce Street
   Bridgeton, NJ 08302

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. However, I need to sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an un-authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about the disclosure of my health information, I can contact Jeffrey T. Contino, D.C of Contino Chiropractic Center.

_____ _____
Patient/Legal Representative Signature Date

_____
If Signed by Legal Representative, State Relationship to Patient

CONDITIONAL ASSIGNMENT OF BENEFITS

PATIENT NAME: _____

MEMBER ID #: _____

MEDICAL PROVIDER'S NAME: _____JEFFERY T. CONTINO, D.C_____

I authorize and request _____ (insurance carrier) to pay directly to the above-named medical provider, the amount due me under the terms of the above-referenced policy as a result of medical care rendered by that medical provider and all medical staff associated with the provider's office.

_____ _____

Patient Signature Date

PREFERRED METHOD OF CONTACT

I, _____, hereby consent and state my preference to have my physician, Dr. Jeffrey T. Contino, and other staff at Contino Chiropractic Center communicate with me by email, in addition to or to replace leaving phone messages, regarding various aspects of my health care, which may include, but shall not be limited to, test results, appointments, and billing. I understand that email messaging is not a confidential method of communication and may be insecure. I further understand that, because of this, there is a risk that email messages regarding my medical care might be intercepted and read by a third party. I give my permission to leave both appointment reminders AND my private health information at the following (please fill-in the ones you agree to):

Phone number_____

Email_____

I give permission to contact me, relative to appointment reminders only, by the following methods:

Phone message at the following number_____

Email messages at the following email address_____