

Guarino Chiropractic

"Mission Statement"

We welcome you as a patient and appreciate the opportunity to provide you with the best quality chiropractic care. Our goal is to make you healthy, happy and wise. Using the latest chiropractic information and technology, we will strive to maintain the highest level of integrity and personal commitment to our patient's healthcare needs. With true sincerity we help and guide people by educating the public about the art, science, philosophy and benefit of chiropractic care to achieve optimal health. We believe changing lives through chiropractic is our purpose...

Touching lives is our gift.

Please Print Clearly and fill in completely.

Print Name: _____ **Your SSN:** _____ - _____ - _____

Street Address: _____ **Phone:** _____

City: _____ **State:** _____ **Zip:** _____ **Date of Birth:** _____

e-Mail: _____ **Emergency Contact & Phone:** _____

Employer's Company Name: _____ **Employer's Work Phone:** _____

Please Check ✓ Sex: Male Female Right handed Left handed Married Single

Health History:

Give reason for seeking chiropractic care: _____

Is this related to an automobile accident or job related injury? Yes No If "Yes", which: _____

Describe any health problems, including how long you've had them: _____

Are you under the care of any other doctor? Yes No

If Yes, please list the doctors you are seeing, the conditions being treated for, and your progress to date.

List any current Medications: _____

List any past surgeries & dates: _____

List any past accidents & dates: _____

Do you smoke tobacco? Yes No If Yes, what type and how often : _____

Patient's Insurance Information:

Insurance Company Name: _____ Phone: _____

ID Number: _____ Group Number: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Subscriber's SSN: ____ - ____ - _____

Personal & Family History:

Your Occupation: _____ Work Duties _____

Spouse's name: _____ Date of Birth: _____ Health status: _____

Spouse's Work Phone: _____ Spouse's Employer: _____

Family Health Information: (Many health problems are the result of hereditary spinal weakness: thus information about your family members will give us a better picture of your total health picture.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

Chiropractic History:

Have you ever been to a Chiropractor before? Yes No If yes Doctor's Name _____

Date of last chiropractic visit _____ Reason for care _____

Date of last chiropractic x-rays _____ How long were you under care? _____

Are other family members under chiropractic care? - Yes No Who? _____

Wellness Commitment

At Guarino Chiropractic we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this, we need to understand your commitment toward being healthy. We do *not* ask for a *financial commitment*, but we do ask for your *cooperative commitment*. Based on a scale of 10% to 100%, please **circle** your personal level of commitment toward obtaining and maintaining health and wellness.

10%----- 20% -----30%----- 40% -----50%----- 60% -----70%----- 80% -----90% ----- 100%

Where did you hear about our clinic or who referred you? _____

FEMALES: Please Check One ✓ Is there a possibility of you being pregnant? Yes No

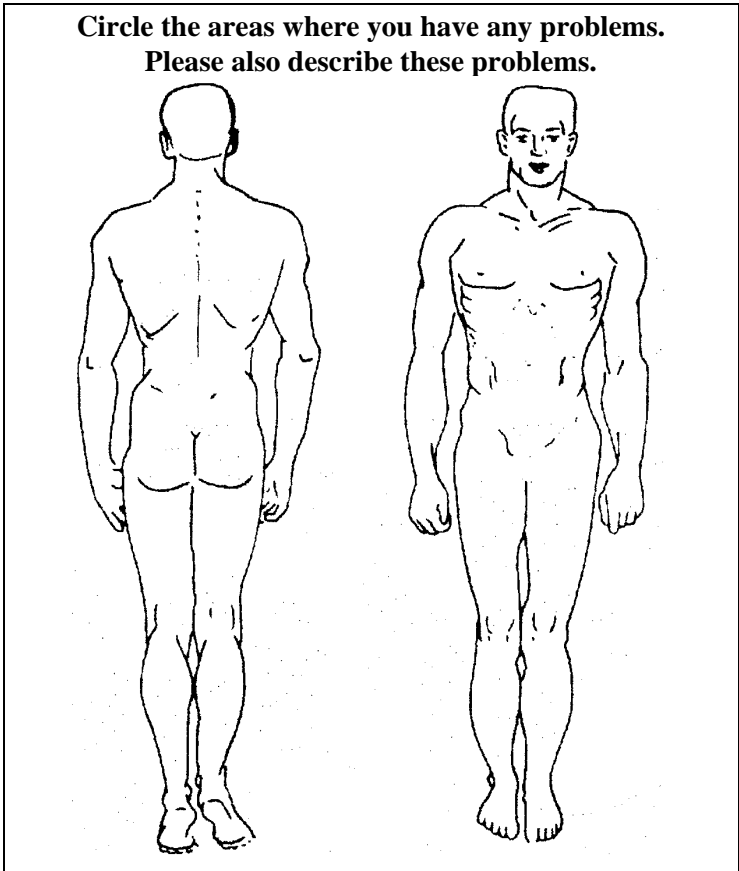
Please Fill in Below

If you have had the following, or if you suffer from the following, Please Check ✓

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arm/Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>
Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>
Leg/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>
Disc Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Other joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Joint Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Vision Changes	<input type="checkbox"/>	<input type="checkbox"/>
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>
Earaches	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Chest pains	<input type="checkbox"/>	<input type="checkbox"/>
Female problems	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Digestive problem	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>
Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>

Skin conditions

Other _____



Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

I understand and agree that health insurance is an arrangement between an insurance carrier and myself. I understand that the Guarino Chiropractic Center will prepare any necessary reports and forms to assist me in making collection from the insurance company and any amount authorized to be paid directly to this office will be credited to my account in a timely manner. However, I clearly understand and agree that all services rendered are charged directly to me and I am personally responsible for payment. It is also my understanding that I will be responsible for paying any fees and costs (including attorney costs) incurred by Guarino Chiropractic Center in getting my account paid in full. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will be immediately due and payable.

Thank you for being complete and thorough.

Your Signature Below Please

Date: _____