Mainiero Family Chiropractic Center
663 N. Main Road
Vineland, NJ 08360

DATE: _____

Confidential Patient Health Record

How did you hear about us? ☐ Family _____ ☐ Friend _____ ☐ Co-Worker _____
☐ Close to home/work ☐ Dr. _____ ☐ Yellow pages ☐ Drove by ☐ Hospital ☐ Insurance Plan

Personal Information

First:_____ **Middle:**_____ **Last:** _____ **Sex: Male / Female**

Address: _____ **Apt #** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone:(_____)_____-_____ **Cell Phone:** (_____)_____ _____

Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated **Birth Date:** ____/____/_____ **Age:**_____

Social Security #: _____-_____-_____ **Fax #:** (_____)_____-_____

Email Address: _____

Emergency Contact

Name: _____ **Phone Number:** (_____)_____-_____

Address: _____

Relationship: ☐ Spouse ☐ Relative ☐ Friend ☐ Other _____

Employment Information

Business Name: _____ **Occupation/Job Title:** _____
Business Address: _____ **Name of Supervisor:** _____

Business Phone: (_____)_____-_____ **Type of Work:**_____

Current Health Condition

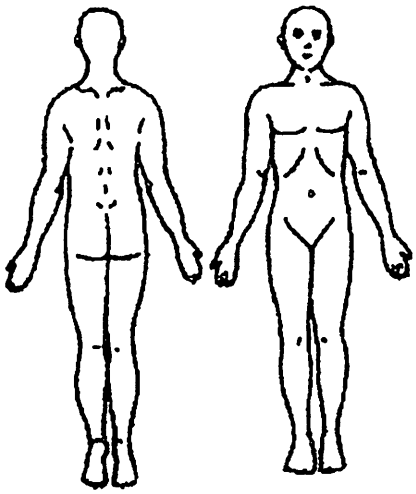
Unwanted Condition (Why you are here today?):_____

_____

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT
→ → → → → → →

Key: A=Ache B=Burning N = Numbness
P=Pins & Needles S=Stabbing



When did this Condition BEGIN? ____/_____/_____

Has it ever occurred before? ☐ Yes ☐ No. **When?** _____

Is the Condition: ☐ Auto Related ☐ Job Related ☐ Home Injury

☐ Slip or Fall ☐ Lifting ☐ Slept Wrong ☐ Unknown Cause ☐ Other

Explain: _____

_____

Date of Accident: _____ **Time of Accident:** _____ **am /pm**

Condition/Pain STARTED on what Date: _____

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REVIEW OF SYSTEMS -Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

Constitutional: ☐ I DENY having or have had any of the symptoms or problems listed below.

☐ chills ☐ daytime drowsiness ☐ fatigue ☐ fever ☐ night sweats
☐ weight gain ☐ weight loss ☐ other:

Eyes/Vision: ☐ I DENY having any of the symptoms or problems listed below.

☐ blindness ☐ blurred vision ☐ cataracts ☐ change in vision ☐ double vision
☐ eye pain ☐ field cuts ☐ glaucoma ☐ itching ☐ photophobia
☐ tearing ☐ glasses ☐ contact lenses ☐ other:

Ears, Nose and Throat: ☐ I DENY having any of the symptoms or problems listed below.

☐ bleeding ☐ dentures ☐ difficulty swallowing ☐ discharge ☐ dizziness
☐ ear drainage ☐ ear pain ☐ fainting ☐ frequent sore throats ☐ headaches
☐ hearing loss ☐ history of head injury ☐ hoarseness ☐ loss of sense of smell ☐ nasal congestion
☐ nosebleeds ☐ postnasal drip ☐ rhinorrhea (runny nose) ☐ sinus infections ☐ snoring
☐ sore throat ☐ tinnitus (ringing in ears) ☐ TMJ problems ☐ other:

Respiration: ☐ I DENY having any of the symptoms or problems listed below.

☐ asthma ☐ cough ☐ coughing up blood ☐ shortness of breath ☐ sputum production
☐ wheezing ☐ other:

Cardiovascular: ☐ I DENY having any of the symptoms or problems listed below.

☐ angina (chest pain or discomfort) ☐ chest pain ☐ claudication (leg pain/ache)
☐ heart murmur ☐ heart problems ☐ high blood pressure
☐ low blood pressure ☐ orthopnea (difficulty breathing lying down) ☐ palpitations
☐ paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath) ☐ shortness of breath with exertion or exercise ☐ swelling of legs
☐ ulcers ☐ varicose veins ☐ other:

Gastrointestinal: ☐ I DENY having any of the symptoms or problems listed below.

☐ abdominal pain ☐ belching ☐ black - tarry stools ☐ constipation ☐ diarrhea
☐ difficulty swallowing ☐ heartburn ☐ hemorrhoids ☐ indigestion ☐ jaundice
☐ nausea ☐ rectal bleeding ☐ abnormal stool caliber ☐ abnormal stool color ☐ abnormal stool consistency
☐ vomiting ☐ vomiting blood ☐ other:

Female: ☐ I DENY having any of the symptoms/problems and/or using any of the items listed below.

☐ birth control ☐ breast lumps/pain ☐ burning urination ☐ cramps ☐ frequent urination
☐ hormone therapy ☐ irregular menstruation ☐ pregnancy ☐ urine retention ☐ vaginal bleeding
☐ vaginal discharge ☐ other:

Male: ☐ I DENY having any of the symptoms or problems listed below.

☐ burning urination ☐ erectile dysfunction ☐ frequent urination ☐ hesitancy/ dribbling ☐ prostate problems
☐ urine retention ☐ other:

Endocrine: ☐ I DENY having any of the symptoms or problems listed below.

☐ cold intolerance ☐ diabetes ☐ excessive appetite ☐ excessive hunger ☐ excessive thirst
☐ abnormal frequency of urination ☐ goiter ☐ hair loss ☐ heat intolerance ☐ unusual hair growth
☐ voice changes ☐ other:

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Skin: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ changes in nail texture ☐ changes in skin color ☐ hair growth ☐ hair loss ☐ hives
☐ history of skin disorders ☐ itching ☐ paresthesias ☐ rash ☐ skin lesions / ulcers
☐ varicosities ☐ other:

Nervous System: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ dizziness ☐ facial weakness ☐ headache ☐ limb weakness ☐ loss of consciousness
☐ loss of memory ☐ numbness ☐ seizures ☐ sleep disturbance ☐ slurred speech
☐ stress ☐ strokes ☐ tremor ☐ unsteadiness of gait ☐ loss of balance
☐ other:

Psychologic: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ anhedonia ☐ anxiety ☐ loss or change in appetite ☐ behavioral change ☐ bi-polar disorder
☐ confusion ☐ convulsions ☐ depression ☐ insomnia ☐ memory loss
☐ mood change ☐ other:

Hematologic: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ anemia ☐ bleeding ☐ blood clotting ☐ blood transfusion ☐ bruising easily
☐ fatigue ☐ lymph node swelling ☐ other:

PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Previous Chiropractic Care: ☐ **I have not previously seen a Chiropractor OR Fill in the information BELOW.**

Doctor's Name: _____ **Location:** _____ **Date of Last Visit:** _____
Were you satisfied with your care? ☐ **Yes** ☐ **No. Why?** _____

Surgery (ies): **LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.**

_____

_____

Females ONLY: **Mark all that apply below.**

I AM: ☐ **currently pregnant** ☐ **NOT pregnant** ☐ **unsure**
Past Pregnancy History: ☐ **C-section** ☐ **vaginal delivery** ☐ **miscarriage**

Injury (ies): **Mark or List All Injuries. Write the DATE of the Injury immediately afterward.**

☐ back injury ☐ broken bones ☐ fall (severe) ☐ fracture
☐ disability (ies) ☐ head injury ☐ loss of consciousness ☐ joint injury
☐ laceration (severe) ☐ motor vehicle accident ☐ soft tissue injury ☐ other:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Print Name: _____ **Patient's Signature:** _____ **Date:** _____

I acknowledge that I have received the Chiropractic Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: _____ **Date:** _____
Patient's Signature: _____ **Date:** _____