utitta hiro ractic

Ne atient Health History orm

,QRUGHU WR VDYH WLPH SOHDVH FRPSOHWH WKLV IRUP DQG
EULQJ LW WR \RXU ILUVW DSSRLQWPHQW $OO LQIRUP

3DWLHQW 'DWD

1DPH BBBBBBBBBBBBBBBBBBBBBBBBB'DWH BBBBBBBBBBBB (PDLO BBBBBBBBBBBBBBBBBBBBB
+HLJKW BBBBBBB"BB""" :HLJKW BBBBB
:PVS FNBJM XJMM /05 CF TIBSFE XJU
JT VTFE GPS HFOFSBM PGGJDF BOOPV
ace aaaaaa ""

Cig"aa aaaa" Dkt WK GDWH BBBBBBB 6HFXULW\ BBBBBBB BBBB UHQBBBBB

&RQWDFW ,QIRUPDWLRQ

$GGUHVV BBBBBBBBBBBBBBBBBBBBBBBB &LW\ BBBBBBBBBBB 6WDWH BBB =LS BBBBBBB
7HOHSKRQH &HOO BBBBBBBBBB BBBBBBBaa Baaaa 5HIHUUHG %\ BBBBBB

2FFXSDWLRQ BBBBBBBBBB (PSOR\HU BBBBBBBBBBBBBBBBBBB BBBBBBaaBBBBBBBBB
5HODWLRQVKLS 6WDWXV BBBBBBBBBBBBBBBB 2FFXSDWLRQ BBBBBBBaB
6SRXVH¶V 1DPH BBBBBBBBBBBBBB 1XPEHU RI FKLOGUHQ BBBBBBBBBBBBBBBBB

Gogtigpe{"eqpvcev" aaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaa" Rjqpg" aaaaaaaaaaaaaaaaaaaaaaaaa

&XUUHQW &RPSODLQWV

1DWXUH RI SUREOHP 2WKHU "
3OHDVH GHVFULEH BBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBB
BBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBB
'DWH RI LQMXU\ BBBBBBBBBBBBBB 'DWH V\PSWRPV DSSHDUHG BBBBBBBBB
+DYH \RX HYHU KDG WKH VDPH FRQGLWLRQ" BBBBBBBBBBBBBBBBBBBBBBBBBBB
/LVW RWKHU SUDFWLRQHUV VHHQ IRU WKLV LQMXU\ FRQGLWLRQ aaaaaaaBBBBBBB
+DYH \RX HYHU EHHQ XQGHU FKLURSUDFWLF FDUH" 1R
,I \HV SOHDVH GHVFULEH BBBBBBBBBBBBBBBBBBBBBBBBBaaaaaaaaBBBBBBB

Kpuwtcpeg" Kphqtocvkqp

'R \RX KDYH LQVXUDQFH" <HV 1DPH RI &RPSDQ\ BBBBBBBaaaaaaaBBBBBBB
,I DQ DXWR DFFLGHQW SOHDVH SURYLGH
,QVXUDQFH &RPSDQ\ 1DPH BBBBBBBBBBBBBBBBBBBB 3KRQH BBBBBa"B" &RQWDFW BBBBBBBBB
3KRQH BBBBBBBBBBBBBBBBBB &ODLP BBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBB

3DWLHQW &RQVHQW

, XQGHUVWDQG WKDW LI , SURYLGH D FHOO QXPEHU , PD\ EH WH[W

,XQGHUVWDQG WKDW , DP UHVSRQVLEOH IRU DOO FKDUJHV LQFXUUHG UHJDUGOHVV RI LQVXUDQFH FRYHUDJH
,XQGHUVWDQG WKDW DOO VHUYLFHV DUH SDLG IRU DW WKH WLPH RI VHUYLFH XQOHVV SUHYLRXVO\ DUUDQJHG
,XQGHUVWDQG WKDW , PD\ EH UHIHUUHG WR DQRWKHU KHDOWK FDUH SURIHVVLRQDO LI QHHGHG DQG FKDUJHV
LPPHGLDWHO\ GXH DQG SD\DEOH

3DWLHQW¶V VLJQDWXUH BBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBB

*XDUGLDQ¶V VLJQDWXUH LI PLQRU BBBBBBBBBBBBBBBBBBBBB 'DWH BBBBBBBBBBBB BBBBB

Medical History

Ha e yo ee treated or a y co ditio si t e last year Bc MYg

=ZmYgž d`YUgY XYgWf]VY SSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSS

8UhY cZ `Ugh d\mg]WU` Y I Ua SSSSSSSSSSSSS =gh\Yf Yd]WU` [bUbWY3 \UP mç i UfY

J c x g { q w j c f Z / t c { u 1 O T q K 1 [E K h U (g p u y ç m g g p A a a a a a a a a a a a a a a a a a

K \Uh a YX]WUh]cbg fYmci hU_]b[bcK 'cf k\UhWcbX]h]cb ?fI D`YUgY]bWcXY XcgU [YUbXUacib hcY2 "

SSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSS

SSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSS

K \Uh j]hUa]bg ž a]bYfU`gž cf \YfVg Xc mci WiffYbh`m hU_Y3 fI D`YUgY `]gh U``]bW`iX]b[Xcgu[Y "

SSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSS

SSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSS

List any allergies to medications: ______________________

Have you ever: No Yes Briefly Explain

Have you ever:	No	Yes	Briefly Explain
Broken bones?			____________________
Been hospitalized?			____________________
Been in an auto accident?			____________________
Had Sprains / Strains?			____________________
Been struck unconscious?			____________________
Had surgery?			____________________

Family History

Family Member	Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Habits:	None	Light	Moderate	Heavy
Alcohol			☐	☐
Caffeine				
Drugs				
Sleep				
Exercise				
Water				
Appetite				
Artificial Sweetners				

Smoking Status (chose one):

- Current Every Day Smoker
- Current Some Day Smoker
- Former Smoker
- Never Smoker

	Yes	No
Do you experience pain every day?		
Do your symptoms interfere with daily life?		
Does pain wake you up at night?		
Are your symptoms worse during certain times of the day?		
Do changes in weather affect your symptoms?		
Do you wear orthotics?		
Do you take vitamin supplements?		
What activities aggravate your symptoms?		

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Cutitta Chiropractic

Informed Consent

The determination of an appropriate plan of chiropractic/physical rehabilitation management for the neuromusculorskeletal conditions may involve or include the utilization of orthopedic, neurologic and physical performance testing and physical, manipulative and exercise/rehabilitative therapies. Should these procedures be deemed appropriate in your case, you will evaluated by the doctor to determine if you have any conditions that indicate you should not engage in any particular test or therapeutic procedure.

I understand that, as with any form of physical activity or exercise, orthopedic, neurologic and physical performance testing and physical, manipulative and exercise/rehabilitative therapies carry with them a small inherent risk of injury which includes but is not limited to minor strains, intervertebral disc compromise, and compression fractures. Additionally, as is the case with most health care interventions, there is a certain (albeit rare) inherent risk of complications associated with chiropractic and rehabilitative procedures. These complications include but are not limited to muscle strains, dislocations, skin irritations, costovertebral strains, fractures, disc trauma, and cardiovascular accidents. I understand my doctor will not be able to anticipate all potential complications, but elect to rely on his clinical expertise and judgment to determine courses of clinical action, based upon known facts, which are considered to be in my best interest. I understand that results are not guaranteed and that I have the opportunity to discuss the purposes and risks associated with all recommended evaluation and treatment procedures at any time.

I have read and understand the preceding statements and herby consent to voluntary participate in orthopedic, neurologic, and physical performance testing and physical, manipulative and exercise/rehabilitative therapies as deemed appropriate by my doctor. If at any time I decide that I am unwilling to engage in these procedures, I reserve the right to inform my doctor of such and not participate in these forms of evaluation or treatment.

Patient/Guardian's Signature________________________________ Date ________

Cutitta Chiropractic

ASSIGNMENT OF BENEFITS, AUTHORIZATION FOR RELEASE OF INFORMATION AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

Assignment of Benefits/Financial Responsibility
The undersigned hereby authorizes ***Cutitta Chiropractic*** (hereinafter "the Provider") to file on my behalf for payment of any medical benefits arising out of any insurance or health plan benefits and hereby assign the benefits to the Provider. I certify that the information reported with regard to my insurance coverage, health care benefits and medical history is accurate and complete. I understand that I am liable for payment to the Provider for all co-insurance, co-pays and deductibles as required by my insurance or health benefits plan and I also acknowledge that I am responsible for payment of any charges not covered by my insurance or health benefits plan. Payment is required at the time services are rendered unless other payment arrangements are made, in advance.

Designation of Authorized Representative
The undersigned also designates the Provider to the fullest extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") as provided in 29 CFR 2560-503-1(b)(4) and under any applicable state and federal law to pursue claims and appeals on my behalf and exercise all rights connected with my health care benefit plan or insurance policy including but not limited to initial claims determinations, appeals of any benefit determinations, obtaining records and related plan documents, claiming on my behalf medical or other health care benefits, pursuing insurance or plan reimbursement and to pursue any other applicable remedies as may be necessary and with regards to my health benefit plan or insurance policy along with any incidental powers and duties to effectuate same.

Authorization for Release of Information
The undersigned authorizes the Provider to release any medical or other information necessary to determine benefits to my insurance carrier, employer, plan administrator, or any other payer including any information regarding my illness and treatments and for the processing of benefits or insurance claims generated in the course of examination or treatment. The undersigned hereby authorizes ________________________(employer) to furnish to the Provider a copy of all health care plan documents or information requested by the Provider and pursuant to 29 U.S.C. § 1024(b)(4), which includes but is not limited to the latest summary plan documents, plan descriptions, latest annual reports, terminal reports, applicable collective bargaining agreements, trust agreements, contracts or other instruments.

Revocation and Acknowledgement
A photocopy of this authorization shall be considered the same as the original and can be used to process insurance or health benefit claims. The undersigned acknowledges that he/she has the right to revoke this authorization and designation of authorized representative, in writing, by sending notification to the Provider; however, the undersigned understands that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Date:_______________ ______________________________________
Patient

Date:_______________ ______________________________________
Insured

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have received a copy of Cutitta Chiropractic LLC's Notice of Privacy Practices.

____ ____________________

Signature of patient or personal representative Date

____

If signed by personal representative, relationship to patient

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Office Use Only:

Our organization has made a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual named below.

Patient name: ____

Refused to sign ☐ Physically unable to sign ☐

(Other)____

____

____

____

Employee Signature:______________________________ Date:______________________