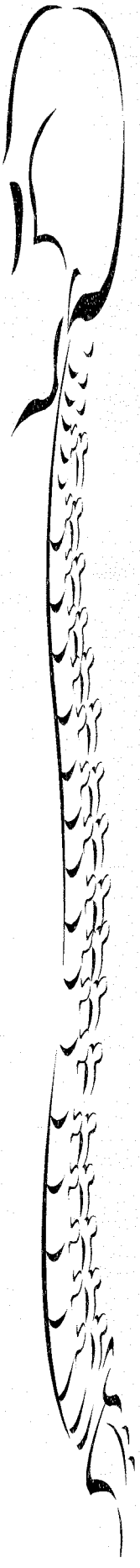


PORZIO CHIROPRACTIC CENTER

1153 West Main Street
Waterbury, CT. 06708
(203) 756-7449

ABOUT YOU

Patient's Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ □ Male □ Female

Birth date: ____/____/____ Age:_____ SS#: _____

Mailing Address: _____

_____
CITY STATE ZIP CODE

Home Phone #: _____

Work Phone#: _____ Ext: _____

Would you like to receive text reminders? Please provide us with you cell phone company carrier. ** NOTICE: Standard text/data charges may apply **

Cell Phone#: _____ Carrier: _____

E-Mail Address: _____

How did you hear about our office?: _____

Employer: _____

Employer Address: _____

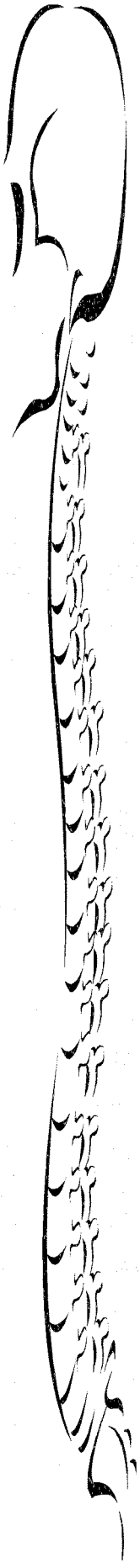
_____
CITY STATE ZIP CODE

Occupation: _____

Status: □ Minor □Single □Married □Divorced □Separated □Widowed

Spouse's Name: _____

Do you have children? □ Yes □ No How many? _____



REASON FOR TODAY'S VISIT

The reason for this visit is a result of (Please circle): auto, work, sports, trauma or chronic

(Explain what happened): _____

_____

Please describe the pain and its location: _____

_____

When did this condition begin? ____/____/____

Is this condition getting worse? □ Yes □ No □ Constant □ Comes and goes

Rate your pain today on a 0-10 scale (Please circle: 0 = no pain and 10 = severe pain)

0 1 2 3 4 5 6 7 8 9 10

Is this condition interfering with your: (Please circle): Work, Sleep, or Daily Routine

If so, please explain: _____

Have you had this similar condition in the past? □ Yes □ No

If so, please explain: _____

Have you been treated by a Medical Physician for this condition? □ Yes □ No

If so, where? _____

Have you ever been treated by a Chiropractor before? □ Yes □ No

If so, whom? _____

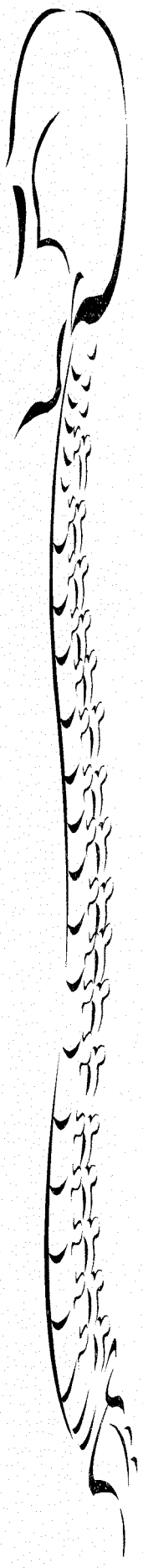
IN THE EVENT OF AN EMERGENCY

Who should we contact? _____

Relation: _____

Home Phone #: _____ Cell Phone #: _____

Who is your Medical Doctor? _____ Phone #: _____



TODAY'S DATE_____

Work Related Accident

Date& Time of Accident: _____ **AM** _____ **PM**

Was your accident directly related to your work?_____

Briefly describe the events that occurred just before and during your accident:_____

_____

_____

Give the address where accident occurred :(if other than employer's address)_____

_____

Was anyone else present during your accident?_____

Has this type of accident happened to you before?_____

Did you report this accident to your employer?_____

Company Name and Contact person: _____

Did you contact an attorney? (if so please give name)_____

_____

Personal Injury Accident

Date & Time of Accident:_____ **AM** _____ **PM**

Briefly describe the events that occurred just before and during your accident:_____

_____

_____

_____

Give the address where the accident occurred: _____

_____

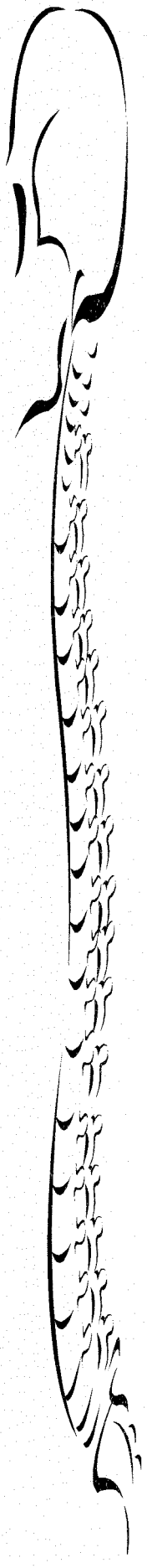
Was anyone else present during your accident?_____

Has this type of accident happened to you before:_____

Did you contact an attorney? (if so please give name)_____

_____

AFTER INJURY



Did accident render you unconscious? □ Yes □ No
If yes, how long? _____

Please describe how you felt immediately after the accident:_____
_____

Have you gone to a Hospital or seen any other Doctor? □ Yes □ No
When did you go? □ Just after accident □ The next day □ 2 days plus
How did you get there? □ Ambulance □ Private Transportation
Name of Hospital and /or Attending doctor: _____

_____

Was he/she a: □ D.C. □ M.D. □ D.O. □ D.D.S.
Describe any treatment you received: _____

_____

Were X-rays taken?	□ Yes	□ No
Was medication prescribed?	□ Yes	□ No
Have you been able to work since this injury?	□ Yes	□ No
Are your work activities restricted as a result of this injury?	□ Yes	□ No

Indicate √ the symptoms that are a result of this accident:

□ Dizziness	□ Difficulty Sleeping	□ Jaw Problems	□ Nausea
□ Memory Loss	□ Irritability	□ Arms/Shoulder Pain	□ Back Pain
□ Headache(s)	□ Fatigue	□ Numb Hands/Fingers	□ Lower back pain
□ Blurred vision	□ Tension	□ Chest pain	□ Back stiffness
□ Buzzing in ear	□ Neck pain	□ Shortness of breath	□ Leg pain
□ Ears ringing	□ Neck stiff	□ Stomach upset	□ Numb Feet/Toes

□ Other _____

Is your condition getting worse? □ Yes □ No □ Constant □ Comes & goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on back	□	□	□
Lying on side	□	□	□
Lying on stomach	□	□	□
Sitting	□	□	□
Standing	□	□	□
Lovemaking	□	□	□
Walking	□	□	□
Running	□	□	□
Sports	□	□	□
Working	□	□	□
Lifting	□	□	□
Bending	□	□	□
Kneeling	□	□	□
Pulling	□	□	□
Reaching	□	□	□

RECOVERY

To evaluate the effect that continuing work will have on your recovery please complete the following:

How many hours are in your normal work day? _____
Please indicate √ your daily job duties and any activities which you are occasionally asked to perform.

□ Standing	□ Driving	□ Operating equipment
□ Sitting	□ Twisting	□ Work w/ arms above head
□ Walking	□ Crawling	□ Typing
□ Lifting	□ Bending	□ Stooping

□ Other _____

What positions can you work in with minimum physical effort and for how long? _____
Prior to the injury were you capable of working on an equal basis with others your age?_____
Do you work with others who can help you with heavy lifting?_____
While in recovery, is there any light duty work you could request? _____

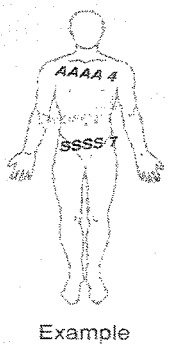
PAIN CHART

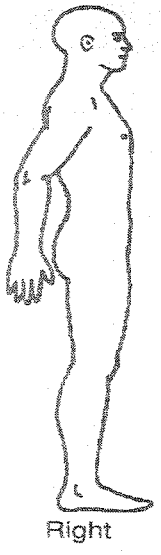
SHOW US WHERE IT HURTS

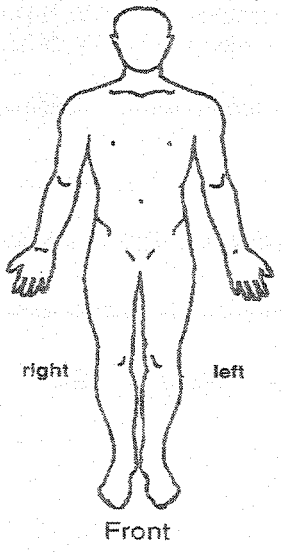
Please mark **area(s)** of injury or discomfort as shown in the example below.

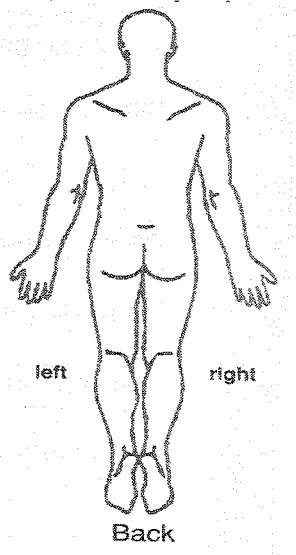
Make all areas with the appropriate symbols and indicate the degree of pain using a scale from **1 (discomfort) to 10 (extreme pain)**

Description →	**Numbness**	**Pins & Needles**	**Burning**	**Aching**	**Stabbing**
Symbol→	*NNNN*	*PPPP*	*BBBB*	*AAAA*	*SSSS*









Do you: Take Supplements or Vitamins? □ Yes □ No Exercise? □ Yes □ No

Are you on a special diet? □ Yes □ No Since: ____/____/____

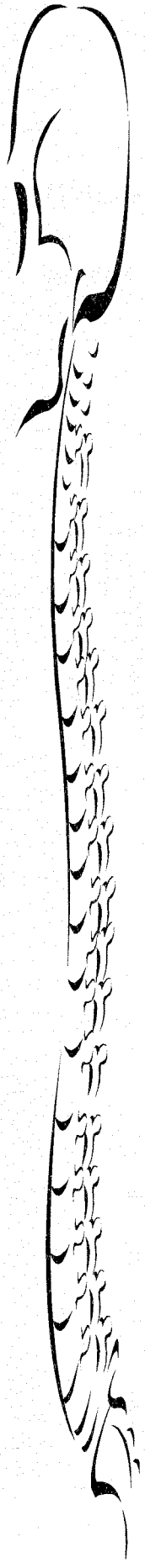
Do you smoke? □ Yes □ No How much? _____ How long? _____

Are you wearing: □ Heel Lifts □ Sole Lifts □ Inner Soles □ Arch Supports

What is the age of your mattress? _____ Is it comfortable? □ Yes □ No

For Women: Are you taking Birth Control? □ Yes □ No

Are you pregnant? □ Yes □ No How long? _____ Nursing? □ Yes □ No



HEALTH HISTORY

Are you taking any of the following medication?

□ Nerve pills □ Pain killers (including aspirin) □ Muscle relaxers □ Stimulants

□ Blood thinners □ Tranquillizers □ Insulin □ Other(s) _____

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack/Stroke	**Y N** Heart Surgery/Pacemaker	**Y N** Heart Murmur
Y N Congenital Heart Defect	**Y N** Mitral Valve Prolapse	**Y N** Artificial Valves
Y N Alcohol/Drug Abuse	**Y N** Venereal Disease	**Y N** Hepatitis
Y N HIV+/Aids	**Y N** Shingles	**Y N** Cancer
Y N Frequent Neck Pain	**Y N** Emphysema/Glaucoma	**Y N** Anemia
Y N High/Low Blood Pressure	**Y N** Psychiatric Problems	**Y N** Rheumatic Fever
Y N Severe/Frequent Headaches	**Y N** Kidney Problems	**Y N** Ulcers/Colitis
Y N Fainting/Seizures/Epilepsy	**Y N** Sinus Problems	**Y N** Asthma
Y N Diabetes/Tuberculosis	**Y N** Difficulty Breathing	**Y N** Chemotherapy
Y N Lower Back Problems	**Y N** Artificial Bones/Joints	**Y N** Arthritis

Please list any other serious medical condition(s) you have or ever had:

_____

Please list anything that you might be allergic to: _____

List previous surgeries/treatments with dates: _____

List any past serious accidents with dates: _____

Family Health History: _____

_____

- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.

- I authorize the staff to perform necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.

- I understand the information I have provided and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibly to inform this office of any changes to the information I have provided.

Signature: _____ Date: _____

□Adult Patient □Parent/Guardian □Spouse

Robert Porzio, D.C. , P.C.
Chiropractic Kinesiologist
1153 West Main St.
Waterbury, Ct. 06708
Telephone (203) 756-7449
Fax(203) 597-1153

I understand that the charges for my treatment in this office for injuries I received as a result of an accident will be submitted to my auto med pay carrier and/or my health insurance. The standard charged per visit is $140.00: broken down as follows- spinal manipulation-$50.00, manual therapy technique-$50.00, therapy such as electric stimulation with hot packs, percussor and/or acupuncture-$40.00. I understand that I am financially responsible for:

My health insurance co-payment for each office visit.

Any treatments which would be over the approved number of visits for my health insurance treatment plan.

All treatments which go beyond the maximum billable amount of my health insurance and or my auto med pay policy.

Therapy charges that are not covered under my health insurance and which are deemed patient responsibility.

Any vitamins or medical supplies(ie: back supports, braces, etc) which Dr. Porzio feels are necessary for treatment program.

NAME:_____

DATE OF INJURY:_____

TODAY'S DATE:_____

PORZIO CHIROPRACTIC CENTER
1153 West Main Street
Waterbury, CT. 06708
(203) 756-7449

Acknowledgment of Receipt of Privacy Notice

I have been presented with a copy of Porzio Chiropractic Center **Notice of Privacy Policies,** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed_____

Date:_____

If not signed by patient, please indicate relationship to patient (e.g., Guardian, HealthCare Administrator)

Relationship:_____

Date:_____

_____

Internal Use Only:
If patient or patient's representatives refuses to sign acknowledgment of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time)_____

By: (name and title):_____

PORZIO CHIROPRACTIC CENTER
1153 West Main Street
Waterbury, CT. 06708
(203) 756-7449

Effective Immediately

As of October 1, 2008, Porzio Chiropractic Center will be implementing a new office policy for missed appointments. Patient must notify the office two hours prior to any appointment that you are unable to keep. Failure to contact our office will result in a missed appointment charge.

Thank you for your cooperation.

_____ _____

Print Name Date

_____

Signature