TANCREDI CHIROPRACTIC & PHYSICAL THERAPY CENTER
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BACKGROUND INFORMATION

Patient Name_____ DOB_____ Age_____ sex m f
Address _____
City _____ St_____ zip _____
Home phone _____ cell _____
Email _____ ss# _____
Marital status s m x d w
Occupation_____
Patient employer _____ phone _____
Address/City/St/Zip _____
_____
Spouse's name_____ phone _____
Spouse or parents employer _____
Address/City/St/Zip _____

Referring physician _____ phone _____
Address/ City/St/Zip _____
_____
Family physician _____ phone_____
Address/City/State/Zip_____
_____

If patient is a minor:
Father _____ ss# _____ DOB _____
Mother _____ ss# _____ DOB _____
Address/City/St/Zip _____
_____

Emergency contact
Name _____ relationship _____
Home phone _____ work phone _____
Cell _____

MEDICAL BACKGROUND INFORMATION

Main complaint / reason for this visit_____

How long has this been a problem_____

Onset date_____Onset of symptoms are/were: (circle one) gradual instant

Frequency of symptoms are: constant intermittent Are symptoms: intensifying resolving

Type of pain (circle): dull pain sharp pain dull ache numbness
tingling burning spasms shooting pains

Pain is relieved by_____ Is condition getting worse? Yes No

Does condition interfere with: work sleep driving daily routines other_____

Circle any diagnostic tests you have had performed regarding this problem?
X-RAY MRI CT SCAN BONE SCAN INJECTIONS

Date of tests taken and place_____

Current medications for this problem_____

Any surgery for this problem? Yes No

Date of surgery, surgeon's name, and place_____

Please circle the conditions if you have or had any of the following:

High Blood Pressure	Diabetes	Cancer
Heart Disease	Type of Diabetes	Shortness of Breath
Dizziness	Circulation Problems	Asthma
Headaches	Osteo Arthritis	Emphysema
Stroke	Rheumatoid Arthritis	COPD
Neurologic	Joint Replacement	Anxiety
Sinus Problems	Broken Bones	Depression
Skin Problems	Digestive Disorders	Other

Do you have a pace maker? Yes No

If you are a female, could you be pregnant? Yes No Last OB/Gyn exam_____

Have you had chiropractic care? Yes No Doctors name_____

Last chiropractic treatment?_____

Have you ever been in an auto accident? Yes No Any residual injuries? Yes No

List residual injuries_____

Date of auto accident _____

Date of last general physical exam_____ Currently under medical care? Yes No

List other doctors that treat you_____

List any past surgical operations and dates_____

_____

Do you smoke?_____ How many years?_____ How much?_____

Do you consume alcohol?_____ How often?_____ How much?_____

Any diseases that run in your family_____

List any allergies_____

List any medications_____

List any supplements_____

_____

Rate your eating habits: Excellent Good Average Fair Poor

Do you exercise? Yes No How often?_____ Type of exercise_____

Do you currently participate is sports? Yes No Sport?_____

Have you ever participated in organized sports? Yes No

If yes, what sport and when:_____

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PERSONAL INSURANCE

Circle person financially responsible for this account SELF SPOUSE PARENT OTHER_____
Person's name_____ DOB _____ ss#_____
Primary Insurance
Company name_____
Policy # _____ Group# _____ Plan name _____
Secondary Insurance
Company name_____ Policy#_____
Group#_____ Plan Name_____
Name of Policy holder_____
Relationship to policy holder_____

Are you seeing the doctor because of a personal injury accident or a job related accident? YES NO
If you answered YES to the above question, please fill the appropriate insurance section in the following.

INJURY

Auto Insurance carrier:_____
Address/City/St/Zip_____
_____
Date of Accident_____ Claim#_____
Policy#_____ Adjuster's name_____
Attorney name and address_____
_____
Please indicate the amount of medical benefits permitted on your policy $_____
Did you elect Full Tort YES NO Limited Tort YES NO

WORKERS COMP

Worker's Compensation insurance carrier_____
Address/City/St/Zip_____
_____Phone_____
Date of Accident_____Claim#_____
Adjuster's name_____ Phone_____
Has this been reported to your employer? YES NO To Whom_____
Employers Company name_____
Address/City/St/Zip_____
_____
Supervisor's name_____ Phone_____
Attorney name and address_____
_____
_____Phone_____

PAYMENT AGREEMENT

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Tancredi Chiropractic and Physical Therapy Center will prepare any necessary reports and forms to assist me in making collections from the insurance company, and that any amount authorized to be paid directly to Tancredi Chiropractic and Physical Therapy Center 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 and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient name (print) _____ HIC# _____

Signed (Patient or Parent if minor) _____Date_____

Signed (Guarantor or spouse's) _____ Date_____

PAIN ASSESSMENT

PLEASE RATE THE QUALITY OF YOUR PAIN
BASED ON A SCALE OF # 0 – 10

INDICATE ON THE FIGURES BELOW
THE AREA OF YOUR PAIN