CerniglioChiropractic

Scotia office
25 Mohawk Ave
Scotia, NY 12302
Phone: (518) 374-8039
Fax: (518) 374-0273

Latham office
654 Watervliet Shaker Rd
Latham, NY, 12110
Phone: (518) 218-4455
Fax: (518) 218-4454

Patient Intake Form

Full Name: _____ Date: ____/____/____
First MI Last

Address: _____ City: _____ State: _____ Zip: _____

Birth Date: ____/____/____ Age: _____ Female: _____ Male: _____

Social Security Number: ____-____-____ Email Address: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Emergency Phone Number: (____) _____

Insurance Information

Insurance Company: _____ Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Relationship to Patient: _____

Policy ID Number: _____ Group Number: _____

Financial Policy

Insurance Coverage

Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Most insurance policies require the beneficiary to pay co-insurance, co-payment and/or a deductible. We will accept your insurance in any of the plans that we are providers with. Certain insurance companies will only allow a particular number of visits per year and/or per diagnosis code. If your insurance company denies your care in total and/or partial with regards to the amount of visits necessary for the treatment of your condition, you will be responsible for the remainder of the balance.

It is our office policy to collect either a co-pay/co-insurance or an estimated insurance deductible at the time of visit.

I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand and agree to the conditions of this policy.

_____ ____/____/____
Signature Date

Please have your insurance card and driver's license ready so they can be copied for the clinic's records

Health Questionnaire

Patient Information

Height: _____ Weight: _____ Blood Pressure: _____/_____

List all prescription, non-prescription medications and supplements you take as well as the associated condition:

_____

List any surgeries or hospitalizations you have had complete with the month and year for each:

_____

List anything you are allergic to: _____

Family History (list all major diseases such as cancer, heart problems, bone diseases and the relation to yourself):

_____

_____

Please list any serious surgeries with dates: _____

Do you exercise? □Yes □ No Hours/week _____What activity(s)? _____

Do you drink alcoholic beverages? □ Yes □ No _____drinks per day/week/month

Are you dieting? □Yes □ No Since:_____

Do you smoke? □Yes □ No _____packs per day How many years have you been smoking? _____

Do you wear? □ Heal lifts □ Arch supports □ Prescription Orthotics

For women: Are you pregnant or nursing? □ Yes □ No If pregnant, how many weeks? _____

Consent for Treatment

Assignment & Release - By signing below, I authorize Cerniglia Chiropractic to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Cerniglia Chiropractic and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred.

I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient.

By signing below, I give my consent for examination and the performance any tests or procedures needed. I understand that, as in all health care, there are some risks to chiropractic treatment which include, but are not limited to: muscle strains, sprains, fractures, dislocations, disc injuries, and strokes.

_____ _____/_____/_____

Signature Date

Medical History

Describe the reason(s) for your doctor visit today: _____

_____

Are you here because of an accident? _____What type? _____

When did your symptoms start? _____

How did your symptoms begin? _____

_____

How often do you experience symptoms? (Circle one) Constantly Frequently Occasionally Intermittently

Describe your symptoms? (Circle all that apply) Sharp Dull ache Numbing Burning Tingling Shooting

Are your symptoms? (Circle one) Getting better Staying the same Getting worse

On a scale of one to ten how intense are your symptoms? Not intense ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

What positions or activities **aggravate** your current symptoms?_____

What positions or activities **relieve** your current symptoms?_____

How do your symptoms interfere with your work or normal activities?_____

_____

Have you experienced these symptoms in the past?_____

History of Treatment

Primary care physician: _____ Phone: _____

Date last seen: _____ May we update them on your condition? ___Yes ____ No

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider: _____

_____

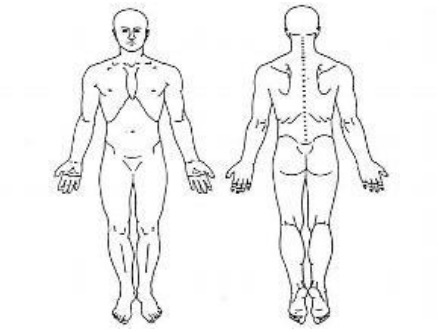
Have you seen a chiropractor before? Yes ____ No____ Who referred you to us? _____

Describe location of problem and draw on diagram.

_____

_____

_____



For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
○	○	Abdominal Pain	○	○	Elbow/upper arm pain	○	○	Liver/Gall Bladder Disorder
○	○	Abnormal Weight gain/loss	○	○	Epilepsy	○	○	Loss of Bladder Control
○	○	Allergies Headache	○	○	Excessive thirst	○	○	Low back pain
○	○	Angina	○	○	Frequent Urination	○	○	Mid back pain
○	○	Ankle/foot pain	○	○	General Fatigue	○	○	Neck pain
○	○	Arthritis	○	○	Hand pain	○	○	Painful Urination
○	○	Asthma	○	○	Heart attack	○	○	Prostate Problems
○	○	Bladder Infection	○	○	Hepatitis	○	○	Shoulder pain
○	○	Birth Control Pills	○	○	High blood pressure	○	○	Smoking/tobacco Use
○	○	Cancer	○	○	Hip/upper leg pain	○	○	Stroke
○	○	Chest Pains	○	○	HIV/AIDS	○	○	Systematic Lupus
○	○	Chronic Sinusitis	○	○	Hormone Therapy	○	○	Thoracic Outlet Syndrome
○	○	Depression	○	○	Jaw pain	○	○	Tumor
○	○	Dermatitis/Eczema	○	○	Joint swelling/stiffness	○	○	Ulcer
○	○	Dizziness	○	○	Kidney Stones	○	○	Upper back pain
○	○	Drug/Alcohol Use	○	○	Knee/lower leg pain	○	○	Wrist pain

Additional comments you would like the doctor to know: _____

_____

_____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ (patient's name) acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Cerniglia Chiropractic, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the practice.

_____ _____/_____/_____

Signature Date

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Inherent Risk of Chiropractic Care

The nature of the chiropractic manipulation
The primary treatment used by doctors of chiropractic is spinal manipulation or adjustments. We will use the procedure in your treatment program unless otherwise stated during the review of findings. We will use our hands to manipulate or loosen and reposition the joints of your spine, restoring biomechanics and moving inflammation. Often with this procedure you will hear a popping noise associated with this.

The material risk inherent to chiropractic manipulation
As with any health care procedure, there are certain side effects and/or complications that may arise from chiropractic manipulation. Local soreness and/or stiffness are typical in the early phases of treatment. Complications may include, but are not limited to: aggravation of degenerative or injured spinal discs, rib fractures, ligaments sprains, muscle strains, nerve injury or spinal cord compression. Manipulation of the neck has been associated with injury to the arteries in the cervical spine leading or contributing to stroke.

Probability of those risks occurring
Fractures are rare occurrences and generally results from underlying bone weakness, which we check for during your history, examination and with any x-rays provided. The incidence of spinal fracture or other serious musculoskeletal injury is estimated at 1:4 million treatments. The exact incidence of stroke is uncertain, but it is generally believed to occur in less than one per million treatments. We employ physical tests that are advocated to screen for this risk, but they are generally accepted as being insensitive. All other complications are also generally described as rare.

The availability and nature of other treatments options include:

- ◊ Over the counter medications and rest
- ◊ Medical care which may include anti-inflammatory drugs, muscle relaxants and pain medication
- ◊ Surgery and injections

Material risk inherent to your other treatment options
The common analgesics and anti-inflammatory drugs prescribed have been shown to cause damage to the stomach and intestines, and possibly to the kidneys. Approximately 1 in 150 patients taking anti-inflammatory drugs for extended periods of time require hospitalization for stomach ulceration. There are about 16,500 deaths in the US each year from these complications which is more common than deaths from either Hodgkin's disease or cervical cancer. The risks are similar for both prescription anti-inflammatories as over-the-counter medications.

Spine surgery may be a consideration for some cases. It, however, is reserved for those cases where extensive conservative treatment has been tried. Spinal surgery is associated with minor complication rates of between 9 per 100 and 15 per 100 cases depending on the area of spinal involvement. More serious complications of the nervous system may occur in 1 per 400 cases and death has been reported in approximately 1 per 1500 cases.

While spinal manipulation is associated with complications in a small number of cases, it has a complication rate of several thousand times less than other typical treatment options.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE
I have read or have had read to me the above explanation of chiropractic manipulation or adjustment and related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below, I state that I have weighted the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Printed Name	Witness Name
Signature	Witness Signature
_____/_____/_____	
Date	

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COVID-19 Screening Form

Please mark next to each statement to demonstrating understanding of the following:

_____ I confirm that I am not currently presenting any of the following symptoms of COVID-19 listed below:

- Temperature above 99.0 F
- Shortness of breath
- Loss of sense of smell or taste
- Dry cough
- Sore throat

_____ I confirm that I have not had any of the above symptoms nor have been in close contact with anyone presenting these symptoms during the last 14 days. If I have any of the above symptoms, come in contact with anyone presenting with these symptoms, or come in contact with anyone who tests positive for COVID-19 during the time that I am under care at Cerniglia Chiropractic, I will make the office aware before appearing for my appointment.

_____ I understand that close contact with people increases the risk of infection from COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and knowingly and willingly give consent to receive chiropractic care.

_____ I understand that my name and contact information might be shared with the state health department in the event that a patient or practitioner at this facility tests positive for COVID-19. My contact details will only be shared in circumstances in which they are relevant based on suspected exposure date, and only for appropriate follow-ups by the health department.

Printed Name _____

Signature _____

Date _____ / _____ / _____