EAST END SPORTS CHIROPRACTIC
STEPHEN J. PETRUCCELLI, DC, CCSP, CSCS

REGISTRATION FORM

Please print. All fields marked with * MUST be completed.

Today's date:

PATIENT INFORMATION

First Name:	Middle:	Last:	Birth Date*: / /	Social Security Number:

Mailing Address:	City:	State:	Zip:

Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )	Email: @

Marital status (circle one) Single / Married / Domestic Partner / Divorced / Separated / Widow(er)	Sex: ❑ M ❑ F

Occupation:	Employer:	Employer phone no.: ( )

Whom may we thank for referring you?

In case of emergency, who should be notified:	Relationship to patient:	Home Phone: ( )	Work Phone: ( )

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for account:	Birth date: / /	Social Security Number:

Address (if different):	Home Phone: ( )

Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insurance Company:	Member #:	Group # (if any):

Secondary Insurance(if applicable):	Subscriber's Name:	Group Number:	Policy Number:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

ASSIGNMENT AND RELEASE

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize East End Sports Chiropractic or insurance company to release any information required to process my claims.

_____ _____

*Patient/Guardian signature** *Date**

EAST END SPORTS CHIROPRACTIC
STEPHEN J. PETRUCCELLI, DC, CCSP, CSCS

HEALTH QUESTIONAIRE

(Please Complete All Information)

Today's date:		
Patient's First Name:	Middle Initial:	Last Name:

PATIENT CONDITION

Reason for visit:

When did your symptoms first appear?

Is this condition getting worse? ❑ Yes ❑ No ❑ Unknown

Rate the severity of your pain, if you have pain (circle one):

0 1 2 3 4 5 6 7 8 9 10

No Pain Severe

Type of pain / symptoms (circle all that apply):

Sharp Dull Throbbing Aching Shooting Burning

Cramping Numbness Swelling Tingling Stiffness Other _____

Does the pain / symptoms interfere with your (circle all that apply):

Work Sleep Daily Routine Recreation

Which, if any, activities / movements are painful or cause symptoms (circle all that apply):

Sitting Standing Walking Bending Lying Down

ACCIDENT INFORMATION

If this condition is due to an accident, what was the date of the accident? / /

Type of accident:

❑ Auto ❑ Work ❑ Home ❑ Other _____

To whom have you made a report of the accident?

❑ Auto Insurance ❑ Employer ❑ Workers Comp ❑ Other _____

Attorney's Name (if applicable):

HEALTH HISTORY

What treatment have you already received for this condition?

❑ Medication ❑ Surgery ❑ Physical Therapy ❑ Chiropractic ❑ None ❑ Other _____

Name(s) of doctor(s) who have already treated you for this condition:

Do you have a pacemaker or any steel pins / rods / screws / etc. implanted anywhere in your body?

❑ No ❑ Yes, describe _____

Do you have any replacement joints? ❑ No ❑ Yes. Where? _____

How many hours of sleep do you normally get? _____hours per night

Type of pillow used? ❑ Thin ❑ Thick ❑ Support/Orthopedic

Do you sleep on your ❑ Back ❑ Side ❑ Stomach

Do you wear: ❑ Orthotics, describe_____ ❑ Shoe Lifts ❑ Arch Supports ❑ Heel lifts

EAST END SPORTS CHIROPRACTIC
STEPHEN J. PETRUCCELLI, DC, CCSP, CSCS

HEALTH QUESTIONAIRE

(Please Complete All Information)

HEALTH HISTORY CONTINUED

Please list any medications you are currently taking.

Have you ever been hospitalized?	❑ No	❑ Yes for	
Have you ever had surgery?	❑ No	❑ Yes for	
Do you have any children?	❑ No	❑ Yes	How many? _____
Gender and ages of children:			

Do you have an immediate family (parents & siblings) history of (please check all that apply):

❑ Diabetes ❑ Heart Disease ❑ Stroke ❑ Cancer

Is yes, please explain

Do you have any allergies?	❑ No	❑ Yes, I am allergic to:
Do you smoke?	❑ No	❑ Yes, packs per
Do you drink alcohol?	❑ No	❑ Yes, drinks per
Do you use any recreational drugs?	❑ No	❑ Yes, explain
Do you exercise regularly?	❑ No	❑ Yes, times per

What type of exercise do you do? _____

Please check if you have had, or currently have, any of the following:

❑ AIDS	❑ Diabetes	❑ Liver Disease	❑ Rheumatic Fever
❑ Alcoholism	❑ Emphysema	❑ Measles	❑ Scarlet Fever
❑ Anemia	❑ Epilepsy	❑ Migraine Headaches	❑ Stroke
❑ Anorexia	❑ Glaucoma	❑ Mononucleosis	❑ Suicide Attempts
❑ Appendicitis	❑ Goiter	❑ Multiple Sclerosis	❑ Thyroid Problems
❑ Arthritis	❑ Gonorrhea	❑ Mumps	❑ Tonsillitis
❑ Asthma	❑ Gout	❑ Osteoporosis	❑ Tuberculosis
❑ Bleeding Disorders	❑ Heart Disease	❑ Pacemaker	❑ Tumors, Growths
❑ Breast Lump	❑ Hepatitis	❑ Parkinson's Disease	❑ Typhoid Fever
❑ Bronchitis	❑ Hernia	❑ Pinched Nerve	❑ Ulcers
❑ Bulimia	❑ Herniated Disc	❑ Pneumonia	❑ Vaginal Infections
❑ Cancer	❑ Herpes	❑ Polio	❑ Venereal Disease
❑ Cataracts	❑ High Cholesterol	❑ Prostate Problem	❑ Whooping Cough
❑ Chemical Dependency	❑ HIV Positive	❑ Prosthesis	❑ Other _____
❑ Chicken Pox	❑ Kidney Disease	❑ Psychiatric Care	❑ Other _____
❑ Fractures	❑ Miscarriages	❑ Rheumatoid Arthritis	❑ Other _____

EAST END SPORTS CHIROPRACTIC
STEPHEN J. PETRUCCELLI, DC, CCSP, CSCS

HEALTH QUESTIONAIRE

(Please Complete All Information)

GENERAL SYMPTOMS

Please check symptoms that you currently have or have had in the past year.

GENERAL

- ❑ Bruise easily
- ❑ Chills
- ❑ Dental Problems
- ❑ Depression
- ❑ Difficulty Sleeping
- ❑ Dizziness
- ❑ Fainting
- ❑ Fever
- ❑ Forgetfulness
- ❑ Headache
- ❑ Loss of Sleep
- ❑ Loss of Weight
- ❑ Nervousness
- ❑ Numbness
- ❑ Sweats
- ❑ Tiredness
- ❑ Weight Gain
- ❑ Weight Loss

GASTROINESTINAL

- ❑ Appetite Poor
- ❑ Bloating
- ❑ Bowel Changes
- ❑ Constipation
- ❑ Diarrhea
- ❑ Excessive Hunger
- ❑ Excessive Thirst
- ❑ Gas
- ❑ Hemorrhoids
- ❑ Indigestion
- ❑ Nausea
- ❑ Rectal Bleeding
- ❑ Stomach Pain
- ❑ Vomiting
- ❑ Vomiting Blood

GENITO-URINARY

- ❑ Blood in Urine
- ❑ Frequent Urination
- ❑ Lack of Bladder Control
- ❑ Painful Urination

CARDIOVASCULAR

- ❑ Chest Pain
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Irregular Heart Beat
- ❑ Poor Circulation
- ❑ Rapid Heart Beat
- ❑ Swelling of Ankles
- ❑ Varicose Veins

SKIN

- ❑ Bruise Easily
- ❑ Hives or Allergies
- ❑ Itching
- ❑ Change in Moles
- ❑ Rash
- ❑ Scars
- ❑ Sore that won't heal

EYE, EAR, NOSE, THROAT

- ❑ Bleeding Gums
- ❑ Blurred Vision
- ❑ Crossed Eyes
- ❑ Difficulty Swallowing
- ❑ Double Vision
- ❑ Earache
- ❑ Ear Discharge
- ❑ Hay Fever
- ❑ Hoarseness
- ❑ Loss of Hearing
- ❑ Nosebleeds
- ❑ Persistent Cough
- ❑ Ringing in Ears
- ❑ Sinus Problems
- ❑ Vision-Flashes
- ❑ Vision-Halos

GENERAL SYMPTOMS-MEN ONLY

- ❑ Lump in Testicles
- ❑ Sore on Penis
- ❑ Erection Difficulties
- ❑ Other _____
- ❑ Chest/Breast Lump
- ❑ Other _____
- ❑ Penis Discharge
- ❑ Other _____

GENERAL SYMPTOMS-WOMEN ONLY

- ❑ Abnormal Pap Smear
- ❑ Hot Flashes
- ❑ Other _____
- ❑ Bleeding between periods
- ❑ Nipple Discharge
- ❑ Other _____
- ❑ Breast Lump
- ❑ Painful Intercourse
- ❑ Other _____
- ❑ Extreme Menstrual Pain
- ❑ Vaginal Discharge

Date of last period / /

Are you pregnant?

Have you entered menopause? ❑ No ❑ Yes Since (year):

HEALTH QUESTIONAIRE

EAST END SPORTS CHIROPRACTIC

STEPHEN J. PETRUCCELLI, DC, CCSP, CSCS

(Please Complete All Information)

BACK, NECK, EXTREMITIES

Please check symptoms you currently have or have had in the past year.

NECK	MID-BACK	LOW-BACK
❑ Pain in neck	❑ Mid-back pain	❑ Low back pain
❑ Neck stiffness	❑ Mid-back stiffness	❑ Low back stiffness
❑ Neck weakness	❑ Pain between shoulder blades	❑ Low back weakness
❑ Pinched nerve in neck	❑ Pain from front to back	❑ Pinched nerve in low back
❑ Pain shooting from neck down arm (s)	❑ Muscle spasms	❑ Pain shooting down back of leg(s)
❑ Muscle spasms		❑ Muscle spasms in low back
❑ Grinding/popping sounds in neck		

Please indicate if symptom(s) occur in the left side, right side or both.

HIPS, LEGS & FEET	LEFT	RIGHT
❑ Pain in buttocks		
❑ Pain in hip joints		
❑ Pain down leg		
❑ Pain in knee		
❑ Pain in ankle		
❑ Pain in foot		
❑ Weakness of leg		
❑ Weakness of knees		
❑ Leg cramps		
❑ Numbness in legs		
❑ Numbness in feet		

SHOULDERS	LEFT	RIGHT
❑ Pain in shoulder joint		
❑ Pain across shoulders		
❑ Can't raise arm above shoulder level		
❑ Can't raise arm over head		
❑ Tension in shoulders		
❑ Pain in front of shoulder/arm		

ARMS & HANDS	LEFT	RIGHT
❑ Pain in upper arm		
❑ Pain in elbow		
❑ Pain in forearm		
❑ Pain in hand		
❑ Pain in fingers		
❑ Pins & needles in arm		
❑ Pins & needles in fingers		
❑ Numbness in arm		
❑ Numbness in fingers		
❑ Weakness in arm		
❑ Weakness in hand		
❑ Hands cold		
❑ Drop things/weak grip		

RELEASE

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

*Patient/Guardian signature** *Date**

_____ _____

Received by Doctor *Date*

EAST END SPORTS CHIROPRACTIC

STEPHEN J. PETRUCCELLI, DC, CCSP, CSCS

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, EAST END SPORTS CHIROPRACTIC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. **I understand that I have the following rights and privileges**:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that EAST END SPORTS CHIROPRACTIC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should EAST END SPORTS CHIROPRACTIC change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

❑ N/A or None

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.
I fully understand and accept / decline the terms of this consent.

_____ _____

Patient's Signature* Date*

FOR OFFICE USE ONLY

[ ] Consent received by _____ on _____.

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on _____.