WELCOME TO DR MUSSO'S CHIROPRACTIC CENTER

TODAY'S DATE: _____/_____/_____ REFERRED BY:_____

Name:_____ What do you prefer to be called:_____
Last First MI

Mailing Address: _____
City State Zip

Phone #: _(_____)_____ Work #:_(_____)_____Ext_____

Cell #: _(_____)_____ E-Mail Address:_____

Birthday: _____/_____/_____ Age:_____ _____

Status: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed

Occupation: _____ Employee Address:_____

Primary Insurance Co.: _____ Policy #: _____Group #_____

Insured's Name:_____ Relationship: ( ) self ( ) spouse ( ) parent ( )other

Patients Height _____ **Weight** _____ **Blood Pressure** _____ Insured's Birthday: _____/_____/_____

Secondary Insurance: _____ Policy #: _____Group #_____

Insured's Name:_____ Relationship: ( ) self ( ) spouse ( ) parent ( )other

Attorney Name_____

Insured's Birthday: _____/_____/_____ Address_____

City_____Phone_____

The more I understand the state of your health, the better I can help you. Also, by New Jersey and federal law, it is required that I obtain all this information, so thank you very much for filling this form out.

Please indicate the Intensity and Frequency of your symptoms below: Example: 10 / D Headache

Intensity: **1** mild pain to **10** severe pain and **Frequency**: **O**: Occasional (1-2 days); **F**: Frequent (3-6 days); **D**:(daily)

_____/_____Headache
_____/_____Rt Jaw
_____/_____Lt Jaw
_____/_____Neck Pain
_____/_____Upper Back Pain
_____/_____Lower Back Pain
_____/_____ Chest Pain
_____/_____Stomach Pain

_____/_____Rt Shoulder Pain
_____/_____Lt Shoulder Pain
_____/_____Rt Elbow Pain
_____/_____Lt Elbow Pain
_____/_____Rt Wrist / Hand Pain
_____/_____Lt Wrist / Hand Pain
_____/_____Rt arm pin / needles
_____/_____Lt arm pins / needles
_____/_____Numbness in Rt fingers
_____/_____Numbness in Lt Fingers

_____/_____Rt Hip Pain
_____/_____Lt Hip Pain
_____/_____Rt Knee Pain
_____/_____Lt Knee Pain
_____/_____Rt Ankle / Foot Pain
_____/_____Lt Ankle / Foot Pain
_____/_____Rt Leg pins / needles
_____/_____Lt Leg pins / needles
_____/_____Rt Toes pins / needles
_____/_____Lt Toes pins / needles

_____/_____ Painful Menstruation
_____/_____ Nervousness
_____/_____ Irritability
_____/_____ Depression
_____/_____ Fatigue
_____/_____ Loss of Memory
_____/_____ Dizziness

_____/_____ Fainting
_____/_____ Loss of Balance
_____/_____ Buzzing in Ears
_____/_____ Face Flushed
_____/_____Loss of Smell
_____/_____Loss of Taste
_____/_____ Cold Sweats
_____/_____ Shortness of Breath

_____/_____Feet Cold
_____/_____Hand Cold
_____/_____Constipation
_____/_____ Diarrhea
_____/_____Fever
_____/_____Head feels Heavy
_____/_____Sleeping Problems
_____/_____ Light Bother Eyes

Do you have any of the following Stress related symptoms?
( ) Headaches ( ) Sinus ( ) Allergies ( ) Asthma ( ) Fatigue ( ) Mood Swings ( ) Depression ( ) Digestive

Please tell Dr. Musso about your primary problem:

1. What primary location bothers you most? _____

2. How did it start? ( ) an injury ( ) sudden ( ) gradually

3. Where were you when you first felt the pain? ( ) home ( ) work ( ) unknown ( ) other

4. How did it happen? ( ) unknown _____

5. When did it start? ( ) Today ( ) Days ago ( ) Weeks ago ( ) Months ago ( ) Years ago

6. Have you had this problem before? ( ) No ( ) If Yes, when?_____

7. Do you have the problem: ( ) Daily - If so, is it: ( ) 100% ( ) 75% ( ) 50% ( ) 25% of the time

8. If you do not have it daily is it: ( ) 3-6 Days per week ( )1-2 days per week or less

9. Is there a time of day when the problem is worse? ( ) no ( ) morning ( ) noon ( ) evening ( ) night ( ) sleeping

10. How much pain is there, rating from 1 to 10 (10 being the worst)? 1, 2, 3, 4, 5, 6, 7, 8, 9, 10

11. What does it feel like? ( )sharp ( )dull ( )achy( )throb ( )tender ( )heavy ( )numb ( )stabbing ( )tingle ( )burn ( )cold

12. What of the following did you tried to do to get rid of the problem, but it did not work?

( )aspirin	( )medication	( )massage	( )wear support / brace	( )family doctor	( )neurologist
( )Tylenol	( )stretching	( )ointments	( )another chiropractor	( )physical therapy	( )ignore it, hoping
( )Advil	( )exercise	( )heat or ice	( )acupuncture	( )orthopedist	it will go away

Do you feel frustrated by having to do the above and it still did not go away? ( ) Yes ( ) No

As a result of having this problem, does it make you feel: ( )sad ( )depress ( )anxious ( )upset ( )mad ( )tired ( ) irritated ( ) tense ( ) nervous ( ) none of these

12. What aggravates your problem?

( )bending	( )standing	( )sitting	( ) any prolonged posture	( ) sex	( ) sports
( )twisting	( ) lying down	( ) walking	( ) standing up from sitting	( ) reaching	( ) exercise
( )lifting	( ) sleeping	( ) running	( ) climbing stairs	( ) driving	( ) moving

13. What can you do to relieve the pain?

( )Nothing	( )Resting	( )Sitting	( )Walking	( )Ice	( )Wearing a support
( )lying down	( )Sleeping	( )standing	( )Moving	( )Heat	( )Over the counter drugs

14. What activities are limited due to your problem?

( )nothing	( )squatting	( )lying down	( )almost any movement	( )daily pet care
( )lifting	( )stooping	( )sleeping	( )repetitive motions	( )lifting children
( )pulling	( )sitting	( )gardening	( )changing positions	( )yard work
( )pushing	( )walking	( )dressing	( )climbing stairs	( )concentrating
( )carrying	( )running	( )driving	( )playing sports	( )urinating
( )reaching	( )jumping	( )working	( )extended computer use	( )bathing
( )twisting	( )resting	( )exercising	( )household chores	( )brushing teeth
( )turning	( )typing	( )cleaning	( )daily children care	( )shaving
( )bending	( )cooking	( )eating	( )going to the bathroom	( )dressing
( )crawling	( )reading	( )having sex	( )caring for infirm family member	( )putting on socks
( )kneeling	( )standing	( )standing	( )coughing and sneezing	( )putting on pants

Life Style Interference

15. When this problem is at its worse, does it make it harder to do your job?

( ) are you less productive on your job ( ) enjoy your work less

( ) have to take more brakes ( ) has your boss said anything about it yet

16. When your problems are at their worse does it affect your relationship with family or friends?

( ) I am less fun to be with ( ) I help less around the house

( ) there are things I cannot do with them Who's more disappointed, You ( ) or Them ( )

17. When the problems are at their worst, does this problem affect your sleep?

( ) Trouble falling asleep ( ) Not enough restful sleep

( ) Awakening in the middle of the night ( ) Waking earlier than normally

18. When the problems are at their worst, it prevents me from doing or enjoying hobby/interest/sport? ( ) Yes ( ) No

What? _____

19. Is there anything else you would do more of or just enjoy more if it wasn't for these conditions? ( ) Yes ( ) No

What? _____

20. Does this problem make you feel older than you are? ( ) Yes ( ) No How much older? _____

21. Would you feel younger if you did not have this problem? ( ) Yes ( ) No How much younger? _____

22. If this problem did not get fixed, would this problem get worse? ( ) Yes ( ) No

Earlier Treating Doctor(s) for the above Problem: ( ) None _____

_____

Any earlier physical traumas:

( )1 car accident	( )work injury	( )fall off chair	( )hit head bottom of pool
( )2 or more car accidents	( )sport injury	( )slip and fall	( )carrying weight on your head
( )motorcycle accident	( )fallen off a horse	( )skiing injury	( )in a fight
( )bicycle accident	( )fall off ladder	( )ocean wave injury	Other:

Do think that the above could attribute to the earlier cause of your current problem? ( ) Yes ( ) No

Please let me know about your Current and Past Health History: Please put the letter C in the ( ) for currently having the condition or a P for having the condition in the Past and it has resolved.

( ) AIDS/HIV	( ) chemical dependency	( ) high blood pressure	( ) polio
( ) alcoholism	( ) depression	( ) low blood pressure	( ) prostate problems
( ) anemia	( ) diabetes	( ) kidney disease	( ) psychiatric care
( ) anorexia	( ) emphysema	( ) liver disease	( ) rheumatoid arthritis
( ) appendicitis	( ) epilepsy	( ) migraine headaches	( ) stroke
( ) arthritis	( ) heart disease	( ) miscarriage	( ) suicide attempt
( ) asthma	( ) hepatitis	( ) multiple sclerosis	( ) thyroid problems
( ) bleeding disorders	( ) hernia	( ) osteoporosis	( ) tumor
( ) breast lump	( ) herniated disc	( ) pacemaker	( ) ulcers
( ) bronchitis	( ) high cholesterol	( ) Parkinson's disease	( ) vaginal infection
( ) bulimia	( ) hypertension	( ) pinched nerve	( ) venereal disease
( )cancer, where_____	( )fractures, where_____	( ) pneumonia	( ) whiplash or obesity

Please let me know your Wellness History and Social History:

# of children ____ ( )pregnant of ___ weeks	( )drinks less than 8 glasses of water daily	( )skip breakfast
( )going through menopause	( )drinks 8 glasses of water daily	Take vitamins ( )Y ( ) N
Drinks alcohol? ( )N ( )Y ( )light ( )moderate ( )heavy	( )go to the bathroom daily	( )Poor sleeper
Smoke cigarettes? ( )N ( )Y ( )light ( )moderate ( )heavy	( )have trouble going to the bathroom	( )Good sleeper
Drink caffeine? ( )N ( )Y ( )light ( )moderate ( )heavy	( )eats three meals per day	Exercise ( )N ( ) Y

What is your current activity exercise level: ( ) none ( ) light ( )moderate ( ) strenuous

Please let me know what drugs you are currently taking:

( ) none	( )anti-coagulant	( )anti-inflammatory	( )cholesterol	( )tranquilizers
( )aspirin	( )high blood pressure	( )painkillers	( )antibiotic	( )anti-acid
( )sleeping pills	( )anti-depressant	( )chemotherapy	( )steroids	( )codeine

Drugs' Name: _____

What are you Allergic to? ( ) None _____

Please let me know about surgeries you have had: ( ) None

( ) appendectomy, when _____ ( ) tonsillectomy, when _____
( ) hysterectomy, when _____ ( ) caesarian section, when_____
( ) Other: _____ when _____
( ) Other: _____ when _____

Please list and date other Hospital stays: ( ) None **Reason**: _____Date:_____
Reason: _____Date:_____ Reason: _____Date:_____

Any reason that will prevent you from receiving treatment? ( ) None ( ) Transportation ( ) Work Schedule

Family Health History

1. Please fill in the AGE of each family member.
2. Under their column put **"C"** for CURRENT health problem.
3. Under their column put **"P"** for a PAST problem.
4. Leave blank those spaces that do no apply.

Condition	Father Age___	Mother Age___	Spouse Age___	Brothers Age___	Age___	Sister Age___	Age___	Children Age___	Age__
Arthritis									
Allergies-Hay Fever									
Back problems									
Cardiovascular Disease									
Cancer									
Constipation									
Diabetes									
Disk Problems									
Emotional Problems									
Emphysema									
Epilepsy									
Headache									
Heart Trouble									
High blood pressure									
Insomnia									
Kidney Trouble									
Liver Trouble									
Migraine									
Osteoporosis									
Pinched nerves									
Scoliosis									
Sinus trouble									
Stomach Problem									
Deceased									

If any of the above family members are deceased, please list their age at death and cause.

_____

_____

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Again, thank you so very much for filling these forms out. Let's get you feeling better!

HIPPA ACKNOWLEDGEMENT OF RECEIPT

As required by the privacy regulation, I hereby acknowledge that I have received a current copy of the notice of Privacy Practices of Dr Joseph Musso's office. I am aware that Dr. Musso's Office has included a provision that it reserves the right to change the terms of the notice and to make the new notice provisions effective for all protected health information that it maintains.

_____

Initial

CHIROPRACTIC AND PHYSICAL THERAPY ACKNOWLEDGMENT

Chiropractic and physical therapy has been noted to be a safe form of treatment for many conditions. As with any physical treatment there are potential risks, most common are: slight bruising, electrical shock, burn and temporary irritation of systems existing prior to treatment. With this knowledge I voluntarily consent to the above procedures.

_____

Initial

INSURANCE ACKNOWLEDGMENT AND AGREEMENT

As a courtesy to our patients, we will call your insurance company to find out what your insurance company will cover for chiropractic treatment at our office. There are times unfortunately, that the insurance company gives wrong information. Therefore, we are not able to guarantee the accuracy of your insurance company's coverage. It is advisable for you to call the company yourself. The only way to know for sure is to bill the company and see what they do pay for.

I understand that Dr. Musso's office is doing me a financial favor by billing my Insurance Company directly and that I at this time I will pay my deductible, Co-payment and any other services not covered by the insurance company. I am ultimately responsible for all services rendered at this office if the insurance company declines payment. It is my responsibility to notify Dr.Musso"s Office of any changes in my Health Care Coverage.

If the Insurance Company does not pay Dr. Musso's fees for services rendered by 60 days, then I will personally call my insurance company and request payment to be made to Dr. Musso. If by 90 days there is no payment, then I will pay Dr. Musso directly and I will wait for the insurance to reimburse me. There will be an added 1.5% financial service charge monthly to any outstanding balance from the date of service. I understand that I will be responsible for any legal fees, collection and other expenses incurred in collecting any money that is owed by me to Dr. Musso.

I hereby authorize assignment of my insurance rights and benefits directly to Dr. Musso for services rendered and I authorize release of any information required to process insurance claims or to other health care providers on my behalf.

_____

Initial

I understand and guarantee that the above information in this form was completed correctly to the best of my knowledge and Understand it is my responsibility to inform this office of any changes to the information I have provided.
I authorize the staff to perform any necessary services needed during diagnosis and treatment

_____ _____ _____

Patient's Printed Name **Signature** **Date**

If signed by a representative of the patient:

_____ _____ _____ _____

Representative's Printed Name **Relationship** **Signature** **Date**