

**7100 Menaul Blvd. NE**  
**Albuquerque, NM 87110**

**Phone: (505) 883-5858**  
**Fax: (505) 883-0010**

Acct #: \_\_\_\_\_ Case#: \_\_\_\_\_

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ ext. \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ e-mail address: \_\_\_\_\_

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Occupation \_\_\_\_\_ Employer/ School \_\_\_\_\_

Name of Spouse/Nearest Relative \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Referred By/How did you hear about us: \_\_\_\_\_

**HAVE YOU HAD ANY PREVIOUS CHIROPRACTIC CARE?**

Yes \_\_\_ No \_\_\_ Date of last adjustment \_\_\_\_\_ Name of Chiropractor \_\_\_\_\_

What was the reason for your initial visit? \_\_\_\_\_

**PRESENT REASON OF CONSULTING OUR OFFICE:** \_\_\_\_\_

How long have you had this injury/symptom/condition? \_\_\_\_\_

Was/is this injury related to an accident? \_\_\_ Yes \_\_\_ No

If Yes, Auto Accident \_\_\_ Work Accident \_\_\_ Other: \_\_\_\_\_

Date of Accident/injury: \_\_\_\_\_

Have you had previous treatment for this injury? \_\_\_ Yes \_\_\_ No

If Yes, what/ where/with whom: \_\_\_\_\_

**PAYMENT/INSURANCE:**

Self Pay: \_\_\_ Yes \_\_\_ No

Health Insurance: \_\_\_ Yes \_\_\_ No Name of Company: \_\_\_\_\_

**Please give the receptionist a copy of your Insurance Card so that we may process your claim.**

**PATIENT PRIVACY:**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.

I HAVE BEEN GIVEN A COPY OF CHIROPRACTIC ARTS **NOTICE OF PRIVACY PRACTICES** (“NOTICE”) OR HAVE BEEN OFFERED A COPY, WHICH DESCRIBES HOW MY HEALTH INFORMATION IS USED AND SHARED. I understand this acknowledgment will be used as authorization to use/disclose PHI for payment, treatment or healthcare operation purposes only. I understand that it may be updated and that I may obtain a current copy.

\_\_\_\_\_ Patient Initial

**ACKNOWLEDGEMENT OF SIGNED HIPAA PRIVACY AUTHORIZATION FOR RELEASE OF INFORMATION.**

\_\_\_\_\_ Patient Initial

**FINANCIAL POLICY:**

We bill most health insurance carriers if proper information is provided to us. **Co-payments, deductibles and non-covered** services are due time of service. Since your agreement with your insurance carrier is a private one, it is understood that you are fully responsible for all charges and balances regardless of insurance. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you. If you are insured by a PPO/POS/HMO plan, it is agreed that you have followed the plan guidelines for obtaining services from said doctor.

Many health insurance carriers will not pay for treatment of injuries sustained in an automobile collision as the automobile insurance carrier is the primary party responsible for medical bills resulting from an automobile collision. Furthermore, some therapeutic modalities necessary in proper treatment of collision related injuries are often not covered by many health insurance policies.

For treatment of injuries sustained in an automobile accident or personal injury accident, you are directly and fully responsible for all bills submitted. If you have insurance that provides medical payment coverage for auto-related or personal injuries, we will bill the insurance carrier directly. Since your agreement with your insurance carrier is a private one, it is understood that you are fully responsible for all charges and balances regardless of insurance. Payment is not contingent on any settlement, judgment or verdict by which a fee may be recovered.

I HAVE READ AND UNDERSTAND THE TERMS OF THE FINANCIAL POLICY. \_\_\_\_\_ Patient Initial

**ASSIGNMENT OF BENEFITS:**

I hereby assign/authorize all medical benefits to be paid directly to Scott M. DelPrete, D.C. This assignment will remain in affect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. **I understand that I am financially responsible for all charges whether or not they are paid by said insurance. If there is an insurance settlement, I understand that I am responsible for paying all charges out of the settlement funds.** I hereby authorize said assignee to release all information necessary to secure the payment.

\_\_\_\_\_  
Patient Signature

Please mark "✓" if you have had any of these symptoms in the last 12 months:

**MUSCULO-SKELETAL SYSTEM**

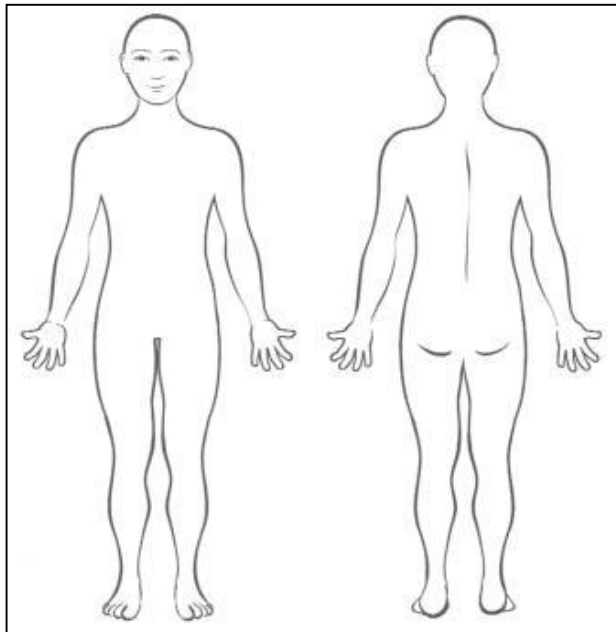
- \_\_\_ Low back problems
- \_\_\_ Pain between shoulders
- \_\_\_ Neck pain/problems
- \_\_\_ Arm pain/problems
- \_\_\_ Leg pain/problems
- \_\_\_ Swollen joints
- \_\_\_ Painful joints
- \_\_\_ Stiff joints
- \_\_\_ Sore muscles
- \_\_\_ Weak muscles
- \_\_\_ Walking problems
- \_\_\_ Low back problems
- \_\_\_ Ruptures
- \_\_\_ Broken bones
- \_\_\_ Low back problems

**REPRODUCTIVE SYSTEM**

- \_\_\_ Impotence
- \_\_\_ Vaginal discharge
- \_\_\_ Vaginal bleeding
- \_\_\_ Vaginal pain
- \_\_\_ Breast pain
- \_\_\_ Lumps in breast

Are you pregnant? \_\_\_ Yes \_\_\_ No

Please mark your areas of pain on the figures below.



**URINARY SYSTEM**

- \_\_\_ Bladder trouble
- \_\_\_ Excessive urination
- \_\_\_ Scanty urination
- \_\_\_ Painful Urination
- \_\_\_ Discolored Urine

**RESPIRATORY SYSTEM**

- \_\_\_ Difficulty breathing
- \_\_\_ Lung problems
- \_\_\_ Persistent cough
- \_\_\_ Coughing blood
- \_\_\_ Coughing phlegm
- \_\_\_ Pain with cough/sneeze

**GASTRO-INTESTINAL SYSTEM**

- \_\_\_ Poor appetite
- \_\_\_ Excessive hunger
- \_\_\_ Difficulty chewing
- \_\_\_ Difficulty swallowing
- \_\_\_ Excessive thirst
- \_\_\_ Nausea
- \_\_\_ Vomiting food
- \_\_\_ Vomiting blood
- \_\_\_ Abdominal pain
- \_\_\_ Diarrhea
- \_\_\_ Constipation
- \_\_\_ Black Stool
- \_\_\_ Hemorrhoids
- \_\_\_ Liver trouble
- \_\_\_ Gallbladder problems
- \_\_\_ Weight trouble

**NERVOUS SYSTEM**

- \_\_\_ Numbness
- \_\_\_ Loss of feeling
- \_\_\_ Paralysis
- \_\_\_ Dizziness
- \_\_\_ Fainting
- \_\_\_ Headaches
- \_\_\_ Muscle jerking
- \_\_\_ Convulsions
- \_\_\_ Forgetfulness
- \_\_\_ Confusion
- \_\_\_ Depression

**CARDIOVASCULAR-SYSTEM**

- \_\_\_ Chest pain
- \_\_\_ Pain over heart
- \_\_\_ Irregular heartbeat
- \_\_\_ Rapid heartbeat
- \_\_\_ Blood pressure problems
- \_\_\_ Heart problems
- \_\_\_ Varicose veins

**EAR-NOSE-THROAT SYSTEM**

- \_\_\_ Eye strain
- \_\_\_ Eye inflammation
- \_\_\_ Vision problems
- \_\_\_ Ear pain
- \_\_\_ Ear noises/ringing
- \_\_\_ Hearing loss
- \_\_\_ Ear discharge
- \_\_\_ Nose pain
- \_\_\_ Nose bleeding
- \_\_\_ Nose discharge
- \_\_\_ Difficulty breathing through nose
- \_\_\_ Sore gums
- \_\_\_ Dental problems
- \_\_\_ Sore mouth
- \_\_\_ Sore throat
- \_\_\_ Hoarseness
- \_\_\_ Difficult speech

**For Physician Use Only**

- Referred pt to ER
- Referred pt to PCP
- Referred pt to Specialist
- Other: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Doctor's Initials \_\_\_\_\_

**TYPE OF PAIN/DISCOMFORT:**

Sharp                      Dull                      Throbbing                      Numbness                      Aching  
Shooting                      Cramps                      Tingling                      Burning                      Stiffness  
Swelling                      Other: \_\_\_\_\_

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your:    Work    Sleep    Daily Routine    Recreation

Activities or movements that are painful to perform:    Sitting    Standing    Walking    Bending    Lying Down

**LIST ALL MEDICATIONS YOU NOW TAKE (prescription and non-prescription):**

What: \_\_\_\_\_

What: \_\_\_\_\_

What: \_\_\_\_\_

**LIST ALL PREVIOUS ACCIDENTS AND/OR INJURIES:**

Falls                      \_\_\_\_\_                      Date: \_\_\_\_\_

Head Injuries                      \_\_\_\_\_                      Date: \_\_\_\_\_

Broken bones                      \_\_\_\_\_                      Date: \_\_\_\_\_

Dislocations                      \_\_\_\_\_                      Date: \_\_\_\_\_

Auto Accidents                      \_\_\_\_\_                      Date: \_\_\_\_\_

**PLEASE LIST ALL SURGERIES YOU HAVE HAD:**

Type \_\_\_\_\_                      Date: \_\_\_\_\_

Type \_\_\_\_\_                      Date: \_\_\_\_\_

Type \_\_\_\_\_                      Date: \_\_\_\_\_

**OCCUPATIONAL STRESSES:**

Repetitive physical positions: \_\_\_\_\_

Heavy/Awkward lifting, explain: \_\_\_\_\_

Other: \_\_\_\_\_

How would you rate your current level of emotional stress: (lowest) 1 2 3 4 5 6 7 8 9 10 (highest)

Do you deal with stress easily or difficultly? \_\_\_\_\_

Do you smoke? Y / N                      How much? \_\_\_\_\_                      How Long? \_\_\_\_\_

Do you consume alcohol? Y / N                      How much? \_\_\_\_\_                      How Often? \_\_\_\_\_

# PATIENT CONSENT TO CHIROPRACTIC TREATMENT

*Please read the following carefully, then sign and date it. Thank You!*

## OUR RESPONSIBILITY

My responsibility to you is to provide the best chiropractic care possible and to educate you as to how to care for your health and how to keep it in top form, if you choose.

## YOUR RESPONSIBILITY

Your responsibility is to learn, to ask questions, and make informed decisions about the recommendations I make for your chiropractic care. You are also responsible for keeping your schedule of care that you have decided to accept our recommendations and you are responsible for payment for your care. Payment is due at the time of service unless you have made specific previous financial arrangements with us. Please inform us if you have insurance that covers chiropractic care. If you have an accident, a surgery, a change of address or any other change in history please advise us on the visit following the change.

## YOUR CARE

The chiropractic adjustment is a quick movement of the vertebrae of the spine, for the purpose of specifically realigning the bone(s) of your spine. Most patients say that the adjustment is comfortable, others may be sore the day after the adjustment(s). The risk of injury during an adjustment is minimal. These risks could include fracture, disk injury or in extremely rare instances, stroke (CVA) can occur. However, controversy exists within the scientific community regarding the chiropractic adjustments and the risk of stroke (CVA). Several studies cited against chiropractic often involve manipulation by other practitioners (PT/LMT/MD/DO) *not* chiropractors.<sup>1</sup> Some authors say that chiropractic care reduces the risk of stroke, others say that the risk is one in a million, to one in five million. The risk of having a subluxation and no care includes degeneration of the affected area and nerve compromise, which affects the health of your entire body. Research suggests that with early intervention, the vertebral subluxation complex can be eliminated. If degeneration occurs, the prognosis for full recovery decreases significantly.

## TERMS OF ACCEPTANCE

When a person seeks chiropractic care and when a chiropractor accepts that person as a patient, essential to the successful relationship is that both parties seek the same goals. My sole intent and goal as a chiropractor is to find and correct the vertebral subluxation complex, to assist you in attaining your optimum health. I do not treat or cure any physical or emotional diseases nor diagnose or give advice about ailments or disease. Please consult with your physician or other appropriate medical provider regarding these medical concerns. I address subluxations and vertebral fixations because I know that your body is self-healing and self-regulating and that, when freed from the effects of the subluxation, it has the innate ability to heal itself. Your body functions at a much higher and more efficient level when I reduce the subluxation because the adjustment maximizes the function of your nerves allowing for freer communication between your brain and your body.

## ACKNOWLEDGMENT:

***I have read and understand this and I agree to its terms and intent.***

Patient's Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_

*Parent/Guardian Authorization for care of a minor child under the age of 18:*

Printed Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Signature: \_\_\_\_\_

Date \_\_\_\_\_

1. Cohn, A. "A Review of Literature Regarding Stroke and Chiropractic." *Journal of Vertebral Subluxation Research*. 4, no. 3(2001):52-59.  
Rome, P.L., "Perspectives: An overview of Comparative Considerations of Cerebrovascular Accidents." *Chiropractic Journal of Australia* 29, no.3(1999):87-102  
Terret, A.G.J., "Misuse of the literature by Medical Authors in Discussing Spinal Manipulative Therapy Injury." *Journal of Manipulative and Physiological Therapies*. 18, n.4 (1995): 203-210.