Scott DelPrete, DC, CCSP, CCEP, CSCS
DelPrete Chiropractic, Inc.

at Chiropractic Arts™

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 by contacting *Lesley Coren, Office Manager*.

_____ 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 and deductibles 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. 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

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

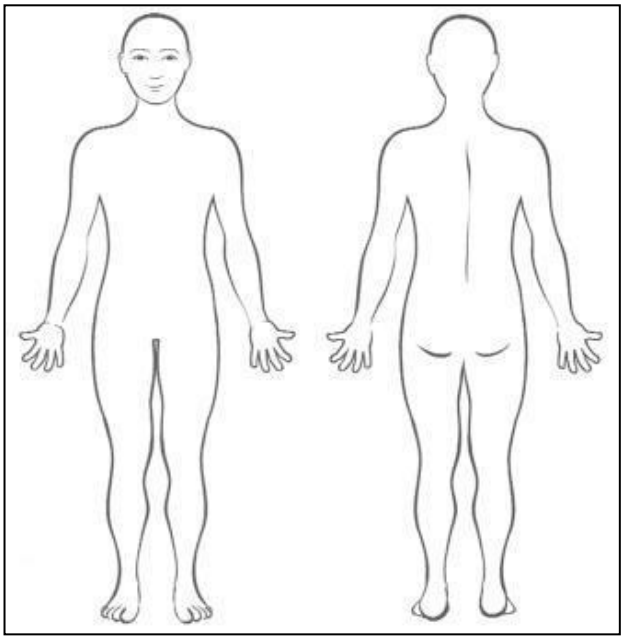
CARDIOVASCULAR-SYSTEM

____ 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

Please mark your areas of pain on the figures below.



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 is 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 <u>ALL</u> 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.[1] 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 Chiropratic." *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.