JOHN GIUGLIANO DC PC

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12 Smith Street, Merrick, NY 11566

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PATIENT INFORMATION

Today's Date:

Name:

Address: **City:** **State:** **Zip:**

Email: **Phone:** ☐ landline ☐ mobile

Birthdate: **Age:** **Sex:** ☐ male ☐ female ☐ other

Status: ☐ minor ☐ single ☐ married ☐ widowed ☐ separated ☐ divorced

Employer: **Occupation:** **How Long?**

Employer's Address: **City:** **State:** **Zip:**

Who may we thank for referring you?

In case of emergency, notify: **Phone:** **Relation:**

INSURANCE INFORMATION

PRIMARY INSURANCE

Insured's Name: **Relation:** **Birthdate:**

Company's Name:

Address: **City:** **State:** **Zip:**

Insured's ID # **Group # (plan, local, or policy)**

SECONDARY INSURANCE

Insured's Name: **Relation:** **Birthdate:**

Company's Name:

Address: **City:** **State:** **Zip:**

Insured's ID # **Group # (plan, local, or policy)**

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REASON FOR VISIT

Reason for today's visit:

Have you been seen by a chiropractor? ☐ YES ☐ NO
Clinic/Dr's Name:

Are you in pain? ☐ YES ☐ NO **Rate your pain on a scale from 1-10:** 1 2 3 4 5 6 7 8 9 10

Did injury occur at: ☐ Work ☐ Sport/Play ☐ Auto Accident ☐ Routine/Household activity

Where and when did injury occur/condition occur?

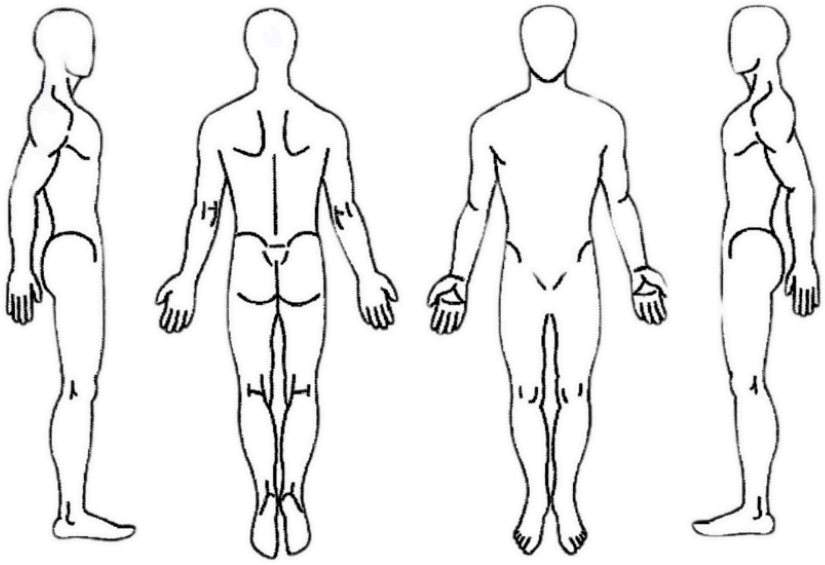
Explain what happened:

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Is your condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine
If so, how?

Has this or something similar happened in the past? ☐ Yes ☐ No
If yes, please explain:

Using the adjacent body charts, please circle all affected areas.



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HEALTH HISTORY

Are you taking any medications? ☐ Yes ☐ No

List of medications you are taking:

Do you have or ever had:

Y N Heart Attack/ Stroke	Y N High/low blood pressure	Y N Glaucoma
Y N Mitral Valve Prolapse	Y N Cancer	Y N Kidney Problems
Y N Shingles	Y N Chemotherapy	Y N Congenital Heart Defect
Y N Alcohol/Drug Abuse	Y N Severe/Headaches	Y N Artificial Valves
Y N Fainting/Seizures	Y N Anemia/ Diabetes	Y N Difficulty Breathing
Y N Frequent Neck Pain	Y N Heart Murmur	Y N Psychiatric Problems
Y N Emphysema/Asthma	Y N Hepatitis	Y N Lower Back Problems
Y N Arthritis	Y N Ulcers/ Colitis	Y N Rheumatic Fever
Y N Heart Surg/pacemaker	Y N Venereal Disease	Y N Tuberculosis
Y N HIV+/AIDS/ARC	Y N Sinus Problems	Y N Artificial Bones/Joints/Implants

Please List any other serious medical condition(s) and/or surgeries not listed above:

Please list any past serious accidents with dates:

Please list any known allergies:

Family health history:

Do you take any supplements or vitamins? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No If yes, how many hours/week?

Do you smoke? ☐ Yes ☐ No If yes, how much? If yes, how long?

Are you wearing ☐ shoe lifts ☐ inner soles ☐ arch supports

Are you dieting? ☐ Yes ☐ No If yes, since _____

For female patients: Are you taking birth control? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No If yes, how far along?

- You are invited to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy is that as a patient, you agree that you will pay for services at the beginning of each visit.
- Our office will gladly prepare and file claim forms, but we cannot guarantee the charges will be paid by the insurance company. You agree and understand that if the insurance denies your claim, that you are financially responsible.
- By signing, you authorize the staff to perform any necessary services needed during diagnosis and treatment. You also authorize the provider to release any information required to process insurance claims.
- You understand the above information and guarantee this form was completed correctly to the best of your knowledge and understand it is your responsibility to inform this office of any changes to the information that you provided.

Patient signature _____ **Date** ____ / ____ / ____