**Dr. Nicholas J. Circolone, Chiropractic Orthopedist,**
**7446 Shallowford Rd, Suite 108, Chattanooga, TN 37421**
**Phone: 423-855-7376 Fax: 423-855-8455 Website: www.drnick.co**

# Patient Information

**Please PRINT in pen legibly and fill out completely.**

**Please allow our office to make a copy of your insurance card/s and license.**

**Name**: _____**Date**: _____

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

**Email**: _____**Social Security Number**: _____

**Birthdate**: _____ **Gender**: ☐Male ☐Female ☐ Other_____

**Ethnicity**
☐ Hispanic/ Latino ☐ Non-Hispanic/ Latino Preferred

**Language**
☐ English ☐ Spanish ☐ Other _____

**Race**
☐ White ☐Black ☐Asian ☐American Indian

**Marital Status**
☐ Married ☐ Single ☐ Divorced ☐Widowed ☐ Living with others

**Home** Phone: _____**Cell Phone**: _____**Work Phone**: _____

**Employer**: _____**Occupation**: _____

**Emergency Contact**: _____**Relation**: _____**Phone**: _____

**Family Physician**: _____**Phone**: _____

**How did you hear about our office**? ☐ Friend ☐ Radio ☐ TV ☐ Internet ☐ Insurance

**If referred by a physician, please provide the name**: _____

## AUTHORIZATION FOR THE TREATMENT, RELEASE OF MEDICAL INFORMATION, AND ASSIGNMENT OF BENEFITS.

I hereby authorize Dr Nicholas J Circolone, Chiropractic Orthopedist, to administer such treatments and release information regarding the treatment or examination rendered to me for medical care to insurance company(s) or their representatives. I also authorize payment to be made directly to Dr Nicholas J Circolone, Chiropractic Orthopedist, in the amount due for all provided services for my eligible dependents or myself. I understand that I am financially responsible for any amounts not covered or paid by my insurance company. Furthermore, I authorize Apple Rehab Group to obtain my medical records from any necessary hospital, clinic, or doctor's office.

**Name:** _____

**Signature:** _____**Date:** _____

# Patient Questionnaire

Chief Complaint Location/Problem(Reason for today's visit):
If yes, Please explain:

_____
_____
_____

If your condition is not due to a recent accident or injury, how long have you had this condition? How did your problem start? Details:

_____
_____
_____

Is the pain: ☐ Occasional ☐ Intermittent ☐ Frequent ☐ Constant

Is the pain: ☐ Sharp ☐ Dull ☐ Aching ☐ Stabbing ☐ Throbbing ☐ Numb ☐ Tight ☐ Tingling ☐ Burning

Please rate your pain on a scale from 1-10 (10 being the worst)

At its worst: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
At rest: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Are you experiencing any of the following: ☐ Locking ☐ Catching ☐ Popping ☐ Grinding?

What makes the symptoms better? ☐ Rest ☐ Ice ☐ Heat ☐ Walking ☐ Standing ☐ Stretching ☐ Exercise ☐ Adjustments ☐ Twisting ☐ Medication ☐ Bending ☐ Working overhead ☐ Lifting ☐ Turning Neck ☐ Movement ☐ Looking up/down ☐ Massage ☐ Other

What makes the symptoms worse? ☐ Rest ☐ Ice ☐ Heat ☐ Walking ☐ Standing ☐ Stretching ☐ Exercise ☐ Adjustments ☐ Twisting ☐ Medication ☐ Bending ☐ Working overhead ☐ Lifting ☐ Turning Neck ☐ Movement ☐ Looking up/down ☐ Massage ☐ Other

What treatments have you tried? ☐ **None** ☐ Rest ☐ Ice ☐ Heat ☐ Exercise ☐ Chiropractic ☐ Physical Therapy ☐ Bracing ☐ Medication ☐ Epidural Injections Massage ☐ Acupuncture

Have you had any of the following tests?
☐ **None** ☐ Xray ☐ MRI ☐ Cat Scan ☐ NCV/EMG What Facility?_____

**Current Medications**

☐ **Not currently taking any medications or vitamins**.

Medications: Please Provide A Copy or list all medications. Including. Prescription and over-the-counter drugs, vitamins, minerals, and herbs.

Medication_____ Dose _____ Frequency _____
Medication_____ Dose _____ Frequency _____
Medication_____ Dose _____ Frequency _____
Medication_____ Dose _____ Frequency _____

**Allergies**

Are you allergic to any medications? ☐ Yes ☐ No ☐ **No known allergies**?

If yes, what is the reaction: ☐ Rash ☐ Anaphylactic ☐ Mild ☐ Moderate ☐ Severe?

If yes, please list all medications/ foods you are allergic to:

Medication_____

Medication_____

Medication_____

**Social History**

Tobacco Use: ☐ Yes ☐ No ☐ Chewing tobacco ☐ Vape ☐ Former

Alcohol Use: ☐ Yes ☐ No Frequency:

Caffeine Use: ☐ Yes ☐ No Frequency:

Recreational Drug Use: ☐ Yes ☐ No If Yes Type and Frequency:_____

**Surgical History**

☐ **Never had any surgical procedures**

Please list any surgical procedures that you have had done in the past, including dates:

Procedure _____ Date _____

Procedure _____ Date _____

Procedure _____ Date _____

Procedure _____ Date _____

Procedure _____ Date _____

**Family History**

**Mother:** ☐ Diabetes ☐ Hypertension ☐ Stroke ☐ Cancer ☐ Arthritis ☐ Seizures ☐ Headaches

**Father:** ☐ Diabetes ☐ Hypertension ☐ Stroke ☐ Cancer ☐ Arthritis ☐ Seizures ☐ Headaches

**Maternal Grandparents:** ☐ Diabetes ☐ Hypertension ☐ Stroke ☐ Cancer ☐ Arthritis ☐ Seizures ☐ Headaches

**Paternal Grandparents:** ☐ Diabetes ☐ Hypertension ☐ Stroke ☐ Cancer ☐ Arthritis ☐ Seizures ☐ Headaches

## Review of systems

**General**

☐ **Deny all** ☐ Fever ☐ Sweats ☐ Chills ☐ Fatigue ☐ Sleep Disturbance

**Musculoskeletal**

☐ **Deny all** ☐ Neck Pain ☐ Back Pain ☐ Joint Pain ☐ Muscle Pain ☐ Muscle Cramp ☐ Muscle Spasm
☐ Joint Stiffness ☐ Swelling in Joints ☐ Jaw Pain ☐ Arthritis ☐ Fractures ☐ Dislocation

**Neurological**

☐ **Deny all** ☐ Headaches ☐ Seizures ☐ Numbness ☐ Tingling ☐ Tremors ☐ Stroke ☐ Dizziness ☐
Fainting ☐ Abnormal balance ☐ Vertigo ☐ Head Trauma ☐ Blacking out ☐ Epilepsy ☐ Difficulty Walking

**EENT**

☐ **Deny all** ☐ Glaucoma ☐ Cataracts ☐ Glasses/contacts ☐ Changes in vision
☐ Blurry Vision ☐ Double Vision ☐ Nasal Congestion ☐ Nosebleeds
☐ Sinus Pain/Pressure ☐ Sore Throat ☐ Mouth: ☐ Cold Sores
☐ Trouble Swallowing ☐ Changes in Taste ☐ Swelling ☐ Respiratory: ☐ Asthma ☐ Shortness of Breath
☐ Cough ☐ Wheezing ☐ Difficulty Breathing ☐ Pneumonia ☐ Coughing up blood ☐ Tuberculosis

**Vascular/Cardiovascular**

☐ **Deny all** ☐ Anemia ☐ Chest Pain ☐ Palpitation
☐ Heart Disease ☐ Hypertension ☐ High Cholesterol ☐ Blood Clots
☐ Bleeding Disorder ☐ Heart Murmur ☐ Ankle Swelling ☐ Cold Hands/Feet ☐ Leg Cramps ☐ Calf Pain
☐ Varicose Veins ☐ Low Blood Pressure

**Gastrointestinal**

☐ **Deny all** ☐ Diarrhea ☐ Constipation ☐ Abdominal Pain ☐ Heartburn ☐ Change in Appetite ☐ Nausea/Vomiting ☐ Gastritis/Ulcer Disease ☐ GERD(Acid Reflux) ☐ Blood in Stool ☐ Hemorrhoids
☐ Gall Bladder Disease ☐ Liver Disease

**Genitourinary**

☐ **Deny all** ☐ Trouble Urinating ☐ Pain with Urination ☐ Blood in Urine ☐ STD ☐ HIV/Aids ☐ Unusual Discharge ☐ Flank Pain ☐ Incontinence ☐ Urinary Infection ☐ Kidney Stones

**Endocrine**

☐ **Deny all** ☐ Excessive Weight Gain/Loss ☐ Excessive Thirst/Hunger ☐ Hot/Cold Intolerance ☐ Diabetes ☐ Thyroid Disease ☐ Hepatitis

**Integumentary**

☐ **Deny all** ☐ Rash ☐ Itching ☐ Lesions ☐ Bruising ☐ Eczema ☐ Hair Loss ☐ Warts ☐ Changes in Moles

**Psychiatric**

☐ **Deny all** ☐ Feeling Anxious ☐ Depressed Mood ☐ Stress Problems ☐ Suicidal Thoughts ☐ Mood Swings

## How would you like to be contacted

We have permission to (please check all that apply):

- ☐Leave messages on the home phone or with household members
- ☐Leave messages on a work phone
- ☐Leave messages on the cell phone
- ☐Confirm appointments by phone or text
- ☐Send emails

This authorization is effective, though (please check one)

- ☐___/_____/_____
- ☐No EXPIRATION unless revoked or terminated by the patient or the patient's representative.

I understand that I may revoke this authorization to disclose information at any time by notifying our office in writing (Termination of Disclosure Form provided on request). If I choose to do so, I am aware that my revocation will not affect any actions taken by this office until the termination request is received in writing and processed.

## Release of Personal Information to Non-Medical Persons

I allow the individuals listed below to have access to the following information contained in my records. (Circle all that apply.). You may revoke this authorization at any time in writing.

☐ MEDICAL ☐ FINANCIAL ☐ BOTH ☐ NONE

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Patient Signature: _____ Date: _____

## HIPPA

Know your Rights. Please Review our HIPAA Policies

Our HIPAA policies are available and posted in our office and on our website. If you would like a copy, please feel free to ask a staff member.

By signing this agreement, you are only acknowledging that you have received or have been given the opportunity to receive a copy of our Notice of Privacy Practices.

Patient Name: _____

Signature: _____ Date: _____

To be completed by office staff:

Staff Signature: _____ Date: _____