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: _____

Preferred Pharmacy: _____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? ☐ Nothing ☐ Rest ☐ Ice ☐ Heat ☐ Exercise ☐ Chiropractic ☐ Physical Therapy ☐ Bracing ☐ Medication ☐ Epidural Injections Massage ☐ Acupuncture

Have you had any of the following tests?
☐ 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 _____
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 Type and Frequency:

Have you ever abused narcotic or prescription drugs? ☐ Yes ☐ No

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

☐ Fever ☐ Sweats ☐ Chills ☐ Fatigue ☐ Sleep Disturbance

Musculoskeletal

☐ Neck Pain ☐ Back Pain ☐ Joint Pain ☐ Muscle Pain ☐ Muscle Cramp ☐ Muscle Spasm

☐ Joint Stiffness ☐ Swelling in Joints ☐ Jaw Pain ☐ Arthritis ☐ Fractures ☐ Dislocation

Neurological

☐ Headaches ☐ Seizures ☐ Numbness ☐ Tingling ☐ Tremors ☐ Stroke ☐ Dizziness ☐

Fainting ☐ Abnormal balance ☐ Vertigo ☐ Head Trauma ☐ Blacking out ☐ Epilepsy ☐ Difficulty Walking

EENT

☐ 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

☐ 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

☐ 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

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

Endocrine

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

Integumentary

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

Psychiatric

☐ 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: _____

Staff Signature: _____ Date: _____