Pecan Country Chiropractic
Dr. Dominic A. Scaramozi, V D.C.
1300 N. King St.
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PECAN COUNTRY
CHIROPRACTIC

Confidential Health Information

_____ **Date:**_____

Who Referred You to Our Office?

_____ ___ _____ _____
First Name **M.** **Last Name** **Suffix**

_____ ___ ___ _____-_____ _____-_____ _____
Date of Birth **Age** **Sex** **Home Phone** **Cell Phone** **Email Address**

_____ _____ _____ _____
Street **City** **State** **Zip Code**

_____ _____ _____-_____
Emergency Contact Name **Relationship** **Emergency Contact Phone**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Legally Separated** ☐ **Widowed**

How would you like to be notified about future appointments? □ **Phone** □**Text** □ **Email**

_____ _____
Your Employer **Address**

_____ _____
Work Phone **Occupation**

*****If under the age of 18 please include Parent/Guardian's information below*****

_____ _____
Name **Date of Birth**

_____ _____
Phone Number **Relationship to Patient**

_____
Address (If Different from Above)

_____ _____ _____
City **State** **Zip Code**

This signature is an acknowledgement that the above information is up to date and accurate to the best of your knowledge.

_____ _____
Signature **(parent/guardian signature if minor under 18)** **Date**

CHIEF COMPLAINT:

Areas of Concern: ☐ Neck/Head ☐ Mid Back ☐ Low Back ☐ Buttocks ☐ Ribs
(Mark all that apply) ☐ L Arm/Shoulder/Elbow/Wrist/Hand ☐ R Arm/Shoulder/Elbow/Wrist/Hand
☐ L Leg/Hip/Knee/Ankle/Foot ☐ R Leg/Hip/Knee/Ankle/Foot

What Symptoms/Conditions have Prompted you to Seek Care Today?_____
_____
_____

What Do You Believe Caused Your Symptoms/Conditions? _____
_____
_____

Date Symptoms/Conditions Started (Please Provide Best Approximation of Month/Year if Unsure):_____

What Relieves Symptoms?: ☐ Cold ☐ Heat ☐ Massage ☐ Meds ☐ Reclining/Resting ☐ Sitting ☐ Sleep ☐ Standing ☐ Movement ☐ Chiropractic Care ☐ Other:_____

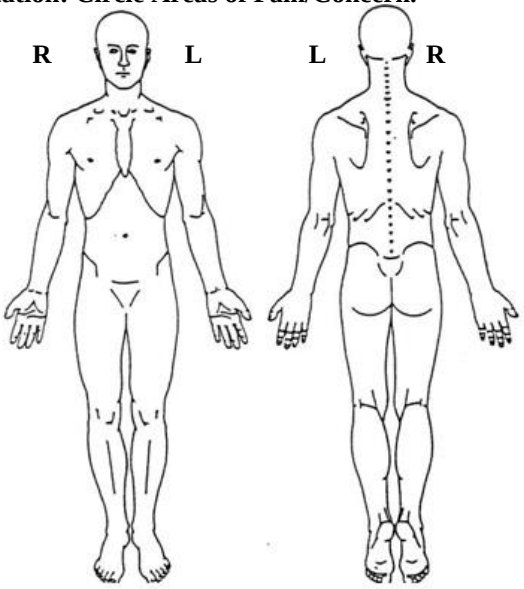
What Aggravates Symptoms?: ☐ Bending ☐ Coughing ☐ Lifting ☐ Running ☐ Sitting ☐ Sneezes ☐ Standing ☐ Turning Head ☐ Movement ☐ Walking ☐ Work ☐ Other:_____

Quality/Pain Type: ☐ Aching ☐ Dull ☐ Numbing ☐ Sharp ☐ Sore ☐ Stiffening ☐ Tingling ☐ Other:_____

Duration: ☐ Hours ☐ Minutes ☐ Days ☐ Weeks ☐ Months ☐ Other:_____

Is there Any Radiating Pain? ☐ Yes ☐ No
If so, where? ☐ R Arm/Hand ☐ L Arm/Hand ☐ R Leg/Foot ☐ L Leg/Foot
☐ Other:_____

Location: Circle Areas of Pain/Concern.



Mark on Diagram:
N=Numbness
S=Sharp/Stabbing
T=Throbbing
A=Ache
D=Dull
X=Stiff/Tight/Spasms
P=Pins and Needles/Tingling
O=Other:_____

Other Symptoms:_____
_____

Prior Interventions/Treatments:_____
_____

Pain Intensity/Severity (0-10: 0=No Pain, 10=Worst Imaginable Pain): _____

Timing/Frequency: ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional ☐ When Stressed ☐ During Physical Activity

Medications Taken for this Condition:_____
_____

REVIEW OF SYSTEMS: (Please Mark All that Apply)

Constitutional:				
□unexplained weight loss	□night sweats	□fatigue	□malaise	□lethargy
□sleeping problems	□loss of appetite	□fever	□itch/rash	□lumps,bumps or masses
ENMT:				
□runny nose	□nose bleeds	□sinus pain	□stuffy ears	□ear pain
□ringing in ears	□gingival bleeding	□sore throat	□pain with swallowing	
Gastrointestinal:				
□abdominal pain	□unintentional weight loss	□difficulty swallowing	□indigestion	□bloating
□cramping	□food avoidance	□nausea/vomiting	□diarrhea/constipation	□inability to pass gas
□vomiting blood	□bright red blood per rectum			
Integumentary:				
□pruritus (itching)	□rashes	□lesions	□wounds	□incisions
□nodules	□tumors	□eczema	□excessive dryness of the skin	
Eyes:				
□visual changes	□headache	□eye pain	□double vision	□blind spots
Cardiovascular:				
□chest pain	□shortness of breath	□ exercise intolerance	□faintness	□palpitations
□loss of consciousness				
Endocrine:				
□hyperthyroid	□hypothyroid	□mood swings	□sweaty	□diarrhoea
□tremor	□palpitations	□depressed	□thin hair	□croaky voice
□diabetes	□hypertension	□low blood pressure	□erectile difficulty	
Genitourinary:				
□incontinence	□vaginal discharge	□painful menses	□hesitancy of urinating	□bladder problems
Hematological/Lymph:				
□anemia	□excessive bleeding	□hemophilia	□purpura	
Respiratory:				
□cough	□wheeze	□shortness of breath	□exercise intolerance	
Musculoskeletal:				
□neck pain, stiff or sore	□hand numbness/pain	□upper arm pain	□shoulder pain	□chest pain
□mid back pain	□arthritis	□mid back burning	□sore mid back	□back pain
□cramps	□knee pain	□sciatica	□low back pain	□leg pain
□weak ankles	□plantar facitis	□foot pain	□weakness in legs	□heel spurs
□hip pain	□spinal curvature	□pain in tailbone with sitting		
Psychiatric:				
□depression	□sleep problems	□anxiety	□difficult concentrating	□paranoia
□paranoia				
Immunological:				
□difficulty breathing	□choking	□swollen lymph nodes/glands	□food allergies	□unusual sneezing
□runny nose	□itchy/teary eyes			
Neurological				
□headaches	□numbness	□tingling	□any changes in sight	□any changes in smell
□any changes in taste	□any changes in hearing	□seizures	□vertigo	□pins & needles
□radiating pain	□blurred vision	□vision difficulties	□balance problems	

FUNCTIONAL CAPACITY INDEX: (Please select only one (1) per row that best describes your situation)

Pain Intensity	□	No Pain	□	Mild Pain	□	Moderate Pain	□	Severe Pain	□	Worst Possible Pain
Sleeping	□	Perfect Sleep	□	Mildly Disturbed Sleep	□	Moderately disturbed sleep	□	Greatly disturbed sleep	□	Totally disturbed sleep
Personal Care (washing, dressing etc.)	□	No pain; no restrictions	□	Mild pain; no restrictions	□	Moderate Pain; need to go slowly	□	Moderate Pain; need some assistance	□	Severe Pain; need 100% assistance
Travel (driving, etc.)	□	No Pain on long trips	□	Mild Pain on long trips	□	Moderate Pain on long trips	□	Moderate Pain on short trips	□	Severe Pain on short trips
Work	□	Can do usual work; unlimited extra work	□	Can do usual work; no extra work	□	Can do 50% of usual work	□	Can do 25% of usual work	□	Cannot work
Recreation	□	Can do all activities	□	Can do most activities	□	Can do some activities	□	Can do a few activities	□	Cannot do any activities
Frequency of pain	□	No Pain	□	Occasional pain; 25 % of the day	□	Intermittent pain; 50% of the day	□	Frequent pain; 75 % of the day	□	Constant pain; 100% of the day
Lifting	□	No pain with heavy weight	□	Increased pain with heavy weight	□	Increased pain with moderate weight	□	Increased pain with light weight	□	Increased pain with any weight
Walking	□	No Pain; any distance	□	Increased pain after 1 mile	□	Increased pain after 1/2 mile	□	Increased pain after 1/4 mile	□	Increased pain with all walking
Standing	□	No pain after several hours	□	Increased pain after several hours	□	Increased pain after 1 hour	□	Increased pain after 1/2 hour	□	Increased pain with any standing

LIST ANY SURGERIES	Date of Surgery
1)	
2)	
3)	
4)	
5)	
LIST ANY KNOWN ALLERGIES	Date Detected
2)	
3)	
4)	
5)	
LIST ANY CURRENT MEDICATIONS	Reason for Meds
1)	
2)	
3)	
4)	
5)	

POSSIBLE CONTRAINDICATIONS: Please Check Yes, No, or Unsure

Do you have or ever had?	YES	NO	UNSURE	**REMARKS:**
Articular Hypermobility Disease	☐	☐	☐	
Severe Demineralization of Bone	☐	☐	☐	
Benign Bone Tumor	☐	☐	☐	
Bleeding Disorder	☐	☐	☐	
Are you Taking Anticoagulants	☐	☐	☐	
Radiculopathy w/ Progressive Neurological Signs, such as Radiating Pain, Numbness, and Weakness	☐	☐	☐	
Rhematoid Arthritis	☐	☐	☐	
Ankylosing Spondylitis	☐	☐	☐	
Fractures	☐	☐	☐	
Dislocations	☐	☐	☐	
Unstable OS Odontodeum	☐	☐	☐	
Malignacies	☐	☐	☐	
Infection of Bones or Joints	☐	☐	☐	
Myelopathy	☐	☐	☐	
Cauda Equina Syndrome	☐	☐	☐	
Vertebrobasilar Insufficiency Syndrome	☐	☐	☐	
Major Artery Aneurysm	☐	☐	☐	

ACCIDENT HISTORY: Please List Most Recent Accidents First

Accident Description	Date of Accident	Treatment Received?
1)		
2)		
3)		
4)		
5)		

Acknowledgements
To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____**

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

If the patient is a minor child, print child's full name: _____

SIGNATURE:_____ DATE:_____

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AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.

2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you, based in whole or in part upon the charges made for your services.

3. In the event any insurance company obligated, by contractual agreement, to make payment to me or to you for the charges made for your services, refuses to make such payment upon demand by you. I herby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute and take action in my name as you see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance companies' proceeds, whether it is all or part of what is due, I personally owe and agree to pay to you.

4. In addition to the above, I herby waive the statute of limitations on collection and/or recovery in this State of Texas.

5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.

6. This Authorization and Assignment will be in continual effect until revoked by both parties.

_____ _____

Patient/Insured Signature Date

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment. Like any other healthcare procedure, there are risks and complications that may occur.

I, _____of do hereby give my consent to the performance of conservative examination and noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Active therapy, exercises, orthopedic tests, range of motion testing and passive and resistant stretches may also be used. Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are certain risks and complications which may arise during chiropractic manipulation and therapy. These complications can include:

Soreness: I am aware that, like exercise, it is common to experience muscle and/or joint soreness after the first few treatments. Any new development of other symptoms should be reported to the doctor immediately.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution. The most common injury we have encountered is **rib sprain/strain** and more rarely, fracture. This injury is more common with those with any history of smoking and/or previous rib cage injuries but can still occur in healthy individuals. Please inform the staff at Pecan Country Chiropractic of any history of short term or long-term smoking habits or injuries suffered to the ribs and sternum (chest bone), including surgical procedures.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.

Pecan Country Chiropractic and its employees will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to their attention, it is your responsibility to inform them. Tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS
I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. I also understand that results from treatment are directly affected by the inability to maintain any prescribed treatment plans and frequency of treatment recommended by the doctor. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE
Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint stability or serious disk injury. Surgical risks may include unsuccessful outcome, increased and/or new complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increases pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____ _____
Signature of Patient Date

_____ _____
Signature of Witness Date