500 Orange Street
New Haven, CT 06511

drcianciolo@aol.com

Dr. John Cianciolo CHIROPRACTIC PHYSICIAN

t. 203-495-6800
f. 203-495-6801

TO THE NEW PATIENT

Welcome to our office. Thank you for choosing us for your chiropractic needs. Our goal is to function as a team to provide our patients with personal attention and quality care. If you need assistance with this form, please do not hesitate to ask a staff member.

Personal Data

Name: ______________________

Gender: ☐ Male ☐ Female

Marital status: ☐ Married ☐ Single ☐ Divorced

Address: ______________________

City: ______________________

State: __________ Zip: __________

Home Phone: ______________________

Cell Phone: ______________________

Email: ______________________

Birth date: ______ ______ ______

Age: ______________________

Occupation: ______________________

Employer/School: ______________________

Address: ______________________

City: ______________________

State: __________ Zip: __________

Phone: ______________________

Emergency Contact

Name: ______________________

Phone: ______________________

Method of Payment

Please present insurance card(s) to the receptionist.

☐ Cash

☐ Health Insurance (present card)

Company: ______________________

☐ Worker Compensation

Claim #: ______________________

☐ Auto Related (present insurance card)

Company ______________________

Claim #: ______________________

☐ Attorney (if applicable)

Name: ______________________

Address: ______________________

City: ______________________

State: __________ Zip: __________

Phone: ______________________

Medical History

Have you had chiropractic care before? ☐ Yes ☐ No

Primary Care Physician's name: ______________________

Approximate date of your last physical ______ ______ ______

Are you currently under a physician's care for a particular condition? ☐ Yes ☐ No

If yes, state condition and treating doctor: ______________________

____

List any operations: ______________________

____

Are you on any medication? ☐ Yes ☐ No

Please notify the doctor of any condition for which you are taking medication, including over-the-counter medication: ______________________

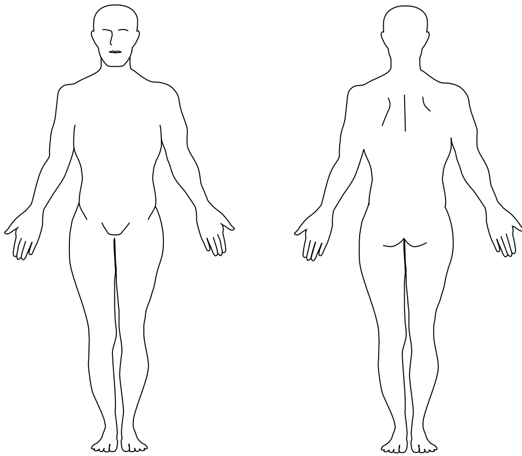
____

Do you have a pacemaker? ☐ Yes ☐ No If yes, please notify the doctor.

Form continues on other side →

PAIN DRAWING

Please indicate location of pain using the symbols noted below on this diagram:



Sharp and Stabbing = ++++
Dull and Achy = oooo
Pins and Needles = vvvv
Numbness = / / / /

Please check any of the following symptoms you have now or have had within the past 3-6 months:

☐ Headaches ☐ Inability to Control Bowel ☐ Constipation
☐ Fever ☐ Inability to Control Urine ☐ Chest Pain
☐ Chills ☐ Urinary Changes ☐ Prostate Trouble
☐ Sweats ☐ Diarrhea ☐ Frequent Urination

Please check any of the following diseases that you have now or have had:

☐ Diabetes ☐ Arthritis ☐ Asthma
☐ Tuberculosis ☐ Stroke ☐ Menstrual Problems
☐ Hypertension ☐ Cancer ☐ HIV
☐ Heart Disease ☐ Epilepsy ☐ Other

Location of type and pain (where does it hurt?) ______________________

How did this happen? ______________________

Have you suffered any recent falls or accidents? ______________________

If new accident or injury give date: ______ ______ ______

Have you lost any days from work? If so, please give details: ______________________

____

For Women

To the best of your knowledge, is there any chance you are pregnant? ☐ Yes ☐ No

If pregnancy is a possiblity, please notify the doctor.

Date of last mentrual period ______ ______ ______

Please sign: ______________________

PATIENT CONSENT

Health Portablity and Accountability Act of 1996 (HIPPA) requires our offices to obtain written patient consent forms before disclosing Protected Health Information (PHI). We respect the privacy of your health care information. Below is a list of circumstances in which we may have to use or disclose your health information.

- We may have to disclose your health information to other health care providers or hospitals for assessment, diagnosis, or treatment of your health condition.
- We have to disclose your health information and billing records to another party if they are potentially responsible for payment of services (i.e.; Insurance Co., Attorney, Third Party Liability).
- We may need to use your health information within our practice for quality control or operational purposes.

We have a HIPPA Office Log which provides a detailed description of how your health information may be use or disclosed. You have the right to limit uses or disclosures of your health information. You may also revoke your consent at any time in writing.

I have read your consent policy and agree to its terms.

______________________ ______________ ______________________
Patient Signature **Date Signed** **Witness Signature**