NORDONIA HILLS CHIROPRACTIC, INC.

8500 North Bedford Road • Macedonia, Ohio 44056 • (330) 468-1199

Dr. Scott A. Sesny, Chiropractic Physician
Dr. Michael R. Scaperato, Chiropractic Physician

Patient Name_____ Today's Date_____

Address_____ City_____ State____ Zip_____

Home Phone_____ Birthdate_____ Age_____

Cell Phone_____ Email_____

SSN_____ Marital Status_____ # Children_____

Occupation_____ Employer_____ Work Phone_____

Spouse Name_____ Spouse Employer_____

Emergency Contact Name_____ Phone_____

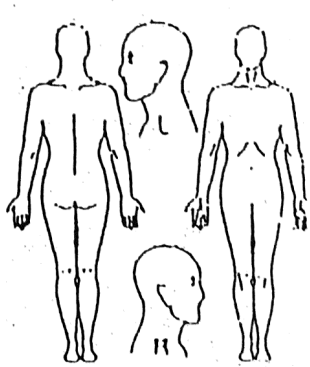
Who can we thank for referring you to our office?_____

Previous Chiropractic care? ☐ Yes ☐ No : Who and # of Visits_____

Reason for today's visit : ☐Health Problem ☐ Wellness Visit / Spinal Check up

If health problem, please describe and shade in areas of symptoms :_____

Doctors Notes: _____



How long have you been suffering from this problem:_____

Describe the characteristics of your symptoms. Check those that apply.

☐Achy ☐Sharp ☐Throbbing ☐Soreness ☐Stiff

☐Tingling ☐Knife-like ☐Sharp w/mvt ☐Spasm ☐Numbness

Rate severity of pain: 0 1 2 3 4 5 6 7 8 9 10

☐Constant pain ☐Comes & Goes ☐Related to Movement

Are symptoms made worse by: ☐Lifting ☐Bending ☐Twisting ☐Lying ☐Sitting

☐Standing ☐Walking ☐Driving ☐Sleeping ☐Stress ☐Sitting to Standing

List previous Trauma (falls, accidents, ect):_____

Have you ever had past or similar problems? ☐Yes ☐No

Muscle Weakness: ☐Yes ☐No Location:_____

Do you have any problems controlling urine or bowel movements? ☐Yes ☐ No

Is pain worse with: ☐Coughing ☐Sneezing ☐Straining
Does anything relieve or reduce the pain? _____

Do you suffer from headaches? ☐Yes ☐ No If yes, how often?_____

Are headaches: ☐Frontal ☐Temporal (L or R) ☐Back of Head ☐Migraine

Previous Treatment: ☐I have not received / tried previous treatment for this condition.

I have tried: ☐Rest ☐Ice ☐Heat ☐Physical Therapy ☐Spinal Manipulation

☐Over the Counter Meds ☐Prescription Meds ☐Massage Therapy ☐Surgery

☐Nutritional Remedies ☐Acupuncture ☐Other (list):_____
Other Doctors seen for this condition: Dr. Name_____Date_____
How effective was this treatment: _____

Patient Medical History: Please check the following that relate to <u>your</u> medical history.

☐Cancer	☐Bone Infection	☐Neuritis	☐Asthma
☐Rheumatism	☐Digestive Disorder	☐Tuberculosis	☐Muscular Dystrophy
☐Epilepsy	☐Venereal Disease	☐Sinus Trouble	☐High BP
☐Concussion	☐Multiple Sclerosis	☐Backaches	☐Heart Trouble
☐Numbness	☐Rheumatic Fever	☐Nervousness	☐Diabetes
☐Dizziness	☐Scarlet Fever	☐Anemia	☐Hepatitis
☐Arthritis	☐Inflammation/ B clots in Veins	☐Other_____	

Please list all past surgeries, fractures, dislocations, and hospitalization & approx dates:

_____

_____

Family Health History: Please indicate if any members of your family has suffered from any of the following conditions or illnesses:

☐Liver Disease☐Cancer ☐Kidney Disease ☐Diabetes ☐Tuberculosis

☐Heart Disease ☐Arthritis ☐Lung Disease ☐Asthma ☐Mental Disease

Check here if adopted☐ ☐Other_____

Additional Information:

Have you ever been in a car accident? ☐Yes ☐No (If yes, please describe with aprox dates)

_____

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

Do you have a pacemaker? ☐Yes ☐No

Are you pregnant? ☐Yes ☐No Due Date: _____

Please list all medications including pain killers, aspirin, cortisone, insulin, or vitamins that you are presently taking_____

_____

Workers comp: If this injury was work related, please describe in detail how it occurred:

_____

_____

_____

Occupation: _____Employed at:_____
Any work missed (date of last date worked):_____

Have you seen any other Dr. for this condition? ☐Yes ☐No Name:_____

Motor Vehicle Accident: Date of Accident:_____ ☐Driver ☐Passenger

Did you go to the ER? ☐Yes ☐No Where:_____

Other Dr. Seen: _____ Were you wearing a seat belt? ☐Yes ☐No
X-Rays taken: _____

Type of Coverage

☐Medical Insurance ☐Worker's Comp ☐Personal Injury (auto accident)

☐Medicare ☐Uninsured (cash)

Method of Payment: ☐Cash ☐Check ☐Credit Card

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to treat 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 for services rendered me by you or any member of your staff acting on your behalf
2. I authorize the direct payment to you of any settlement of my case, and 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. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if I terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Date: _____Signed:_____