

 Dr. Andria Marie D’Amato

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*Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth Date\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_ Sex: ( M F)*

First Middle Last

*Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_

*Home Ph.\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Ph\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Ph*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Contact Preference? (home/work/cell)*

*Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Driver’s License #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_Marital Status: (M S D W)*

*Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*\_ *Name of Insured*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Emergency Contact Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*\_Phone *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Ethnicity (please circle)* Caucasian African American Asian Hispanic Other *Primary Language\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Notice of Privacy Practices

In accordance with the Protected Health Information Act (PHI) our office will, without asking your express consent or authorization, use and disclose your PHI for the purposes of:

* Treatment
* Payment
* Health Care Options
* Advice of Appointments and Services
* Directory/Sign-In Log
* Court Orders, Subpoenas and Government Investigations
* Advise Family/Friends directed by you to receive information regarding your health or

to assist in the payment of your bill.

You have the right to revoke, request special limits or conditions, to receive communication by more confidential means or at alternate locations, to inspect and copy your PHI, and to amend your PHI.

Copies of the NPP may be obtained upon request. Our office strives to maintain HIPAA compliance.

I understand that by signing the above statement I have been notified of my rights in compliance with HIPPA regulations. I have been advised that I may request a complete copy of these rights available through the HIPAA officer at this location.

***Signature****:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Date****:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Consent to Treat Minor****:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_****Date****:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*What is your current complaint?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Is this condition due to: Auto accident Work injury Other accident Illness Unknown cause*

*Date symptoms appeared \_\_\_\_\_\_\_\_\_\_\_\_ Briefly describe what you think caused your pain­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 *What aggravates your condition? Standing Sitting Walking Twisting Lying Lifting*

*Are your symptoms: List all surgeries: List Prescription drugs*

  *Improving \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

  *About the same \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 *Getting worse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 *Comes and goes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Do you use chewing tobacco? Yes or No Allergies to Medications:*

*Are you a smoker? Yes or No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Stress Level:*  *Little or no*   *Minimal*  *Moderate*   *Greatly stressed*

*Exercise:*  *No exercise program Light Moderate Strenuous*

*Physical* Activity: *Sitting 50% or more Light labor*  *Heavy labor*  *Repeated motions*

*Do you have high blood pressure? YES or NO? Do you have Diabetes? If YES, Type I or Type II? Or NO?*

*Have you had these symptoms before? No*  *Yes When\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Pregnant:*  *No*  *Yes Due\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *N/A*

Who is your family doctor?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had chiropractic or acupuncture care before?\_\_\_\_\_\_\_\_\_\_When?\_\_\_\_\_\_\_\_\_\_\_XRays/MRI\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*How did you hear about our office?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Your e-mail address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Signature****:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Date****:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Consent to Treat Minor****:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_****Date****:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***OFFICE USE ONLY:***

*Exacerbation : YES or NO If yes, date and MOI\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Amended treatment plan\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_New Diagnosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*If smoker CPT 400F Date:\_\_\_\_\_\_\_\_\_\_\_ CPT 4001F Date: \_\_\_\_\_\_\_\_\_\_\_*

*Blood Pressure: \_\_\_\_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_ (R/L)Pulse: \_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_*