

Rocco Chiropractic, PLLC
811 Ridge Road, Suite 102
Webster, NY 14580
(585) 671-7170

PATIENT INFORMATION	INSURANCE INFORMATION
<p style="text-align: right;">Date _____</p> <p>Patient _____</p> <p>Address _____</p> <p>_____</p> <p>E-Mail Address: _____</p> <p>Sex: <input type="checkbox"/> M <input type="checkbox"/> F Age _____ Birthdate: _____</p> <p>Occupation _____</p> <p>Employer _____</p> <p>Employer Address: _____</p> <p>Employer Phone: _____</p> <p>Primary Care Physician: _____</p> <p>Primary Care Physician's Address: _____</p> <p>_____</p> <p>Whom may we thank for referring you? _____</p> <p><u>Spouse Information:</u></p> <p>Spouse's Name _____</p> <p>Birthdate _____ Occupation _____</p> <p>Spouse's Employer _____</p> <p>Work Phone: _____ Cell Phone: _____</p>	<p>Subscribers Name: _____</p> <p>Relationship to Patient? _____</p> <p>Insurance Co. _____</p> <p>Employer: _____</p> <p>Insurance ID: _____ Group # _____</p> <p>Is patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Subscriber's Name _____</p> <p>Birthdate: _____ Employer: _____</p> <p>Relationship to Patient _____</p> <p>Insurance Co. _____</p> <p>Insurance ID: _____ Group # _____</p> <p>Insurance Information Release</p> <p>I, the undersigned, certify that I (or my dependent) have insurance coverage with _____. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor and Rocco Chiropractic, PLLC to release all information necessary to process my insurance benefits claim. I authorize the use of this signature on all insurance submissions.</p> <p>_____</p> <p>Responsible Party Signature</p> <p>_____</p> <p>Patient's Signature (Parent/Guardian if Minor)</p> <p>_____</p> <p>Relationship to Patient _____ Date _____</p>
PHONE NUMBERS	ACCIDENT INFORMATION
<p>Home: _____ Work: _____ Cell: _____</p> <p>Best time and place to reach you _____</p> <p>IN CASE OF EMERGENCY, CONTACT:</p> <p>Name _____ Relationship _____</p> <p>Home Phone _____ Work _____ Cell: _____</p>	<p>Is this condition due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____</p> <p>Type of accident: <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Other</p> <p>To whom have you made a report of your accident?</p> <p><input type="checkbox"/> Auto Insurance <input type="checkbox"/> Employer <input type="checkbox"/> Worker Comp. <input type="checkbox"/> Other</p>

Doctor's Signature: _____ Date: _____

Pain Questionnaire

PATIENT'S NAME: _____

DOB: _____

When did your pain begin? _____ Is your pain related to an injury? Yes No

Please describe how it began: _____

Where is your pain?

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Head | <input type="checkbox"/> Forearm Rt. / Lt. / Both | <input type="checkbox"/> Low Back Rt. / Lt. / Both | <input type="checkbox"/> Groin Rt. / Lt. / Both |
| <input type="checkbox"/> Neck Rt. / Lt. / Both | <input type="checkbox"/> Hand Rt. / Lt. / Both | <input type="checkbox"/> Buttocks Rt. / Lt. / Both | <input type="checkbox"/> Knee Rt. / Lt. / Both |
| <input type="checkbox"/> Shoulder Rt. / Lt. / Both | <input type="checkbox"/> Upper Back Rt. / Lt. / Both | <input type="checkbox"/> Hips Rt. / Lt. / Both | <input type="checkbox"/> Calf Rt. / Lt. / Both |
| <input type="checkbox"/> Upper Arms Rt. / Lt. / Both | <input type="checkbox"/> Chest Rt. / Lt. / Both | <input type="checkbox"/> Leg Rt. / Lt. / Both | <input type="checkbox"/> Foot Rt. / Lt. / Both |

Describe your pain:

- | | | | |
|-----------------------------------|------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Stabbing | <input type="checkbox"/> Dull | <input type="checkbox"/> Achy |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Burning | <input type="checkbox"/> Cramping |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling | <input type="checkbox"/> Pressure-like | <input type="checkbox"/> Other _____ |

How often do you experience the pain?

- | |
|--|
| <input type="checkbox"/> Constantly |
| <input type="checkbox"/> Intermittently (comes & goes) |
| <input type="checkbox"/> Other _____ |

What aggravates your pain?

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Sitting down | <input type="checkbox"/> Sitting for Long Periods | <input type="checkbox"/> Standing | <input type="checkbox"/> Standing for Long Periods |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Walking for Long Periods | <input type="checkbox"/> Lying Down | <input type="checkbox"/> Flexing Forward |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Coughing | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Straining |
| <input type="checkbox"/> Deep Breathing | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Specific Movements _____ | |
| <input type="checkbox"/> Other _____ | | | |

What relieves your pain?

- | | | | | |
|--|-----------------------------------|-------------------------------------|---|-------------------------------|
| <input type="checkbox"/> Sitting down | <input type="checkbox"/> Ice | <input type="checkbox"/> Exercise | <input type="checkbox"/> Stretching | <input type="checkbox"/> Rest |
| <input type="checkbox"/> Moist Heat/Shower | <input type="checkbox"/> Walking | <input type="checkbox"/> Lying Down | <input type="checkbox"/> Therapy | |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Massage | <input type="checkbox"/> Medications: _____ | |
| <input type="checkbox"/> Other _____ | | | | |

Since your pain began, is it: Better Worse About the same

Have you resumed your normal activities of daily living? Yes No

Are you disabled from your usual employment? Yes No Type of work _____

If so, what is the date you were last able to work? _____

Previous treatment

What type of treatment have you received for this problem?

- | | | |
|--|--|---|
| <input type="checkbox"/> Physical Therapy _____ | <input type="checkbox"/> None | <input type="checkbox"/> Trigger Point Injections or Nerve Blocks _____ |
| <input type="checkbox"/> Chiropractic _____ | <input type="checkbox"/> Surgery _____ | |
| <input type="checkbox"/> Acupuncture _____ | <input type="checkbox"/> Massage _____ | |
| <input type="checkbox"/> Epidural Steroid Injections _____ | <input type="checkbox"/> Other _____ | |

Diagnostic Testing

What diagnostic tests have you completed so far and when?

- | | | | |
|--|--|---|-------------------------------|
| <input type="checkbox"/> MRI Cervical Spine _____ | <input type="checkbox"/> MRI Lumbar Spine _____ | <input type="checkbox"/> MRI Other _____ | <input type="checkbox"/> None |
| <input type="checkbox"/> X-Rays Cervical Spine _____ | <input type="checkbox"/> X-Rays Lumbar Spine _____ | <input type="checkbox"/> X-Rays Other _____ | |
| <input type="checkbox"/> Cat Scan _____ | <input type="checkbox"/> EMG/NVC _____ | <input type="checkbox"/> Other Tests _____ | |

Doctor's Signature: _____

Date: _____

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PATIENT'S NAME: _____

DATE: _____

Social & Family History

Marital Status: Married Single Widowed Divorced

Live with: Family Spouse Significant Other Friend Other

Children: Yes No Ages: _____

Education Level: Grade School High School College [Associates Bachelors Masters PhD] Trade School

Previous Occupations: _____

Smoking History: Never Currently In the Past Years: _____ Amount: _____ Year Quit: _____

Alcohol: No Yes Amount: _____ Type: _____ Substance Abuse: No Yes Type: _____

Medical History

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Any Known Allergies (Including Medications)	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker
<input type="checkbox"/>	<input type="checkbox"/>	Latex Allergy	<input type="checkbox"/>	<input type="checkbox"/>	Any other heart problem
<input type="checkbox"/>	<input type="checkbox"/>	History of Cancer or Tumor	<input type="checkbox"/>	<input type="checkbox"/>	History of blood clots/phlebitis
<input type="checkbox"/>	<input type="checkbox"/>	History of radiation	<input type="checkbox"/>	<input type="checkbox"/>	History of any blood disorder
<input type="checkbox"/>	<input type="checkbox"/>	History of chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	History of ulcers
<input type="checkbox"/>	<input type="checkbox"/>	History of surgery	<input type="checkbox"/>	<input type="checkbox"/>	History of intestinal hemorrhage
<input type="checkbox"/>	<input type="checkbox"/>	Previous hospitalizations	<input type="checkbox"/>	<input type="checkbox"/>	History of depression/anxiety disorder
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Recent unexplained weight changes
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease/problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease/problems
<input type="checkbox"/>	<input type="checkbox"/>	Collagen vascular disease/problems	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease/problems
<input type="checkbox"/>	<input type="checkbox"/>	Lyme disease	<input type="checkbox"/>	<input type="checkbox"/>	Prostate disease/problems (Men)
<input type="checkbox"/>	<input type="checkbox"/>	Exposure to HIV, AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Ovarian/Uterine disease problems (Woman)
<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or vertigo
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or Hepatitis C Exposure	<input type="checkbox"/>	<input type="checkbox"/>	History of TIA (Transient Ischemic Attack)
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	History of stroke
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Loss of consciousness (Black out/fainting)
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	History of seizures
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Multiple sclerosis
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Migraine headaches
<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Chronic headaches
<input type="checkbox"/>	<input type="checkbox"/>	History of tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Blurred/double vision
<input type="checkbox"/>	<input type="checkbox"/>	Angina/chest pain/irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	Other Neurological problems
<input type="checkbox"/>	<input type="checkbox"/>	Leg pain with walking	<input type="checkbox"/>	<input type="checkbox"/>	Drug dependency
<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol addiction
<input type="checkbox"/>	<input type="checkbox"/>	History of rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Metal fragments in body
<input type="checkbox"/>	<input type="checkbox"/>	History of heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Are you currently pregnant?
<input type="checkbox"/>	<input type="checkbox"/>	Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	Anorexia/Bulimia
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Goiter
<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	Herniated disk
<input type="checkbox"/>	<input type="checkbox"/>	Suicide attempts	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Prosthesis (Metal Plates, Joint Replacements, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Auto Immune Disease

Doctor's Signature: _____

Date: _____

Medication History

PATIENT'S NAME: _____ **DOB:** _____

Yes	No		Yes	No		
<input type="checkbox"/>	<input type="checkbox"/>	For Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	To help you sleep	Please list all that you are currently taking: <ul style="list-style-type: none"> ● Medications (Prescriptions or over the counter) ● Dosage & How often taken ● Vitamins, herbs or minerals <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<input type="checkbox"/>	<input type="checkbox"/>	For a heart problem	<input type="checkbox"/>	<input type="checkbox"/>	To calm your nerves	
<input type="checkbox"/>	<input type="checkbox"/>	For high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	For depression	
<input type="checkbox"/>	<input type="checkbox"/>	To reduce body fluids	<input type="checkbox"/>	<input type="checkbox"/>	For pain	
<input type="checkbox"/>	<input type="checkbox"/>	To thin the blood	<input type="checkbox"/>	<input type="checkbox"/>	For muscle spasm	
<input type="checkbox"/>	<input type="checkbox"/>	For asthma	<input type="checkbox"/>	<input type="checkbox"/>	For bladder control	
<input type="checkbox"/>	<input type="checkbox"/>	For bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Steroids	
<input type="checkbox"/>	<input type="checkbox"/>	For another lung problem	<input type="checkbox"/>	<input type="checkbox"/>	Birth control pills	
<input type="checkbox"/>	<input type="checkbox"/>	For stomach or bowel problems	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	
<input type="checkbox"/>	<input type="checkbox"/>	For glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Other medications not listed	
<input type="checkbox"/>	<input type="checkbox"/>	To reduce your cholesterol				

Family History

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Back problems
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer/stomach problems
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Mental illness
<input type="checkbox"/>	<input type="checkbox"/>	History of Heart Attacks	<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Circulation problems
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems/Disease	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems (Males)

Patient's Signature: _____ **Date:** _____

Parent/Guardian Signature (Minors): _____ **Date:** _____

Doctor's Signature: _____ **Date:** _____

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**NOTICE OF PRIVACY FOR:
PATIENT'S PROTECTED HEALTH INFORMATION**

This notice describes how health care information about you may be used and disclosed and how to get access to this information. Please review it carefully.

This office abides by the terms described in this policy.

This office uses and discloses your protected health care information for the following reasons:

- To share with other treating health care providers regarding your health care.
- To submit to insurance companies or Worker's Compensation Claim to verify that treatment has been rendered.
- To determine patient's benefits in a health care plan.
- Releasing information required by State or Federal Public Health law.
- To assist in overcoming a language barrier when caring for a patient.
- Business associates providing written assurance for your privacy have been attained.
- Emergency situations.
- Abuse, neglect, or domestic violence.
- Appointment reminders to household members or answering machines.
- Mailings for appointments reminders, birthday cards, bills, and other correspondence.
- Sign-in logs may be disclosed to verify office visits.

Any other uses of disclosures will only be made with your specific written prior authorization.

Please note the Doctors of Rocco Chiropractic; PLLC may deliver care in an open office environment (door open). It is understood that if a patient needs to speak on a matter of personal privacy it is the sole responsibility of the patient to request a private area for discussion purposes.

You have the right to:

- Revoke authorization, in writing at any time by specifying what you want restricted and to whom.
- Speak to our privacy officer who is: Dr. Laurie A. Rocco.
- Inspect copy and amend your health information and amend it as allowed by law.
- Obtain an accounting of disclosures of your protected health information.
- To render a complaint to our privacy officer or the Secretary of Health and Human Services.

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received and reviewed this notice with full understanding.

Print patient's name

Signature of patient

Date

Print parent/guardian's name

Signature of parent/guardian

Date