

CASH PATIENT QUESTIONNAIRE

- PLEASE ANSWER ALL QUESTIONS COMPLETELY -

PATIENT INFORMATION:	DATE: _____
Name: _____	SS #: _____
Sex: Male / Female	E-mail address: _____
Marital Status: S M D W	Primary Language: _____
Race: Caucasian Black Asian Other Ethnicity	Ethnicity: Hispanic Non-Hispanic
Birth date: _____ - _____ - _____	Age: _____ Are you a minor? _____
Address: _____	_____
Street Address	Town State Zip code
Home Phone: () _____	Cell Phone: () _____
<i>* please indicate which number is best to reach you at*</i>	

EMPLOYMENT INFORMATION:
Employer /Business Name: _____
Phone #: () _____ EXT: _____
Address: _____
Job Title: _____

I, _____, fully understand that I am directly and fully responsible for any and all payment of services rendered to me by South Shore Chiropractic, PC.

Signature _____

Print Name _____

Date _____

How were you referred to our office? : _____

PAIN DRAWING

Name: _____

Today's Date: _____

Examiner: _____

TELL US WHERE YOU HURT.

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache >>>>
>>>>

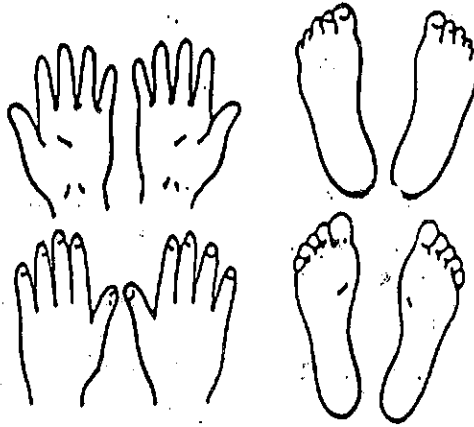
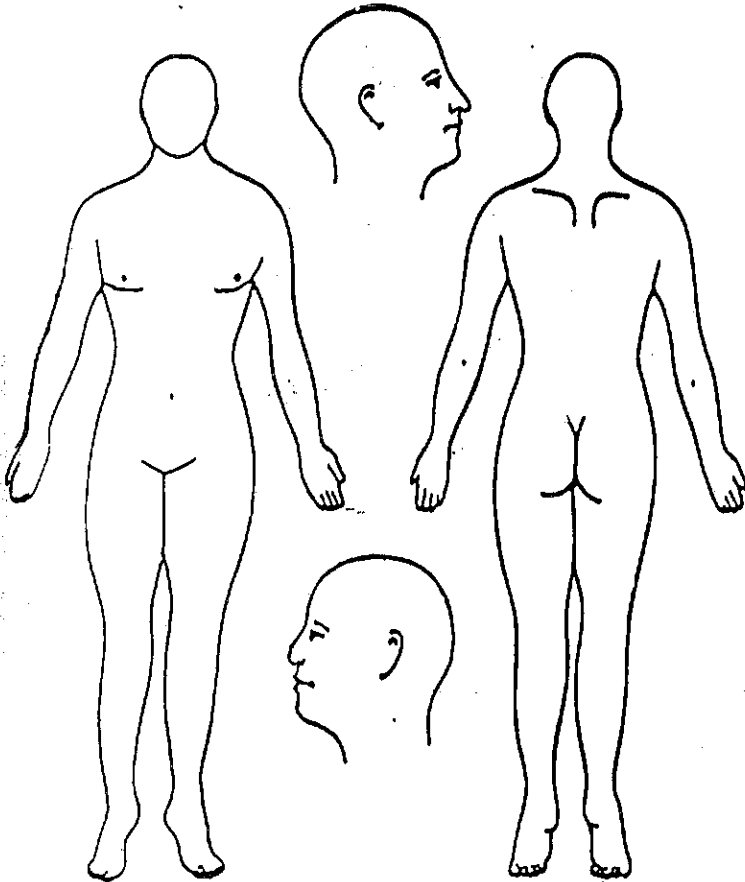
Numbness - - - -
- - - -

Pins and Needles o o o o
o o o o

Burning x x x x
x x x x

Stabbing / / / /
/ / / /

Throbbing - - - -
- - - -



SEVERITY OF PAIN
List region of pain and circle severity number. (1 = least, 10 = greatest)

ex. Neck
1 2 3 4 5 6 7 8 9 10

1. _____
1 2 3 4 5 6 7 8 9 10
2. _____
1 2 3 4 5 6 7 8 9 10
3. _____
1 2 3 4 5 6 7 8 9 10
4. _____
1 2 3 4 5 6 7 8 9 10
5. _____
1 2 3 4 5 6 7 8 9 10

HEALTH QUESTIONNAIRE

PLEASE CHECK ALL THAT APPLY:

MUSCULO SKELETAL SYSTEM

- Low back problems
- Pain between shoulders
- Neck problems
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Rupture
- Broken bones

GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on breast
- Are you pregnant?
- Yes No

GASTRO-INTESTINAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting food
- Vomiting blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

CARDIO VASCULAR RESPIRATORY SYSTEM

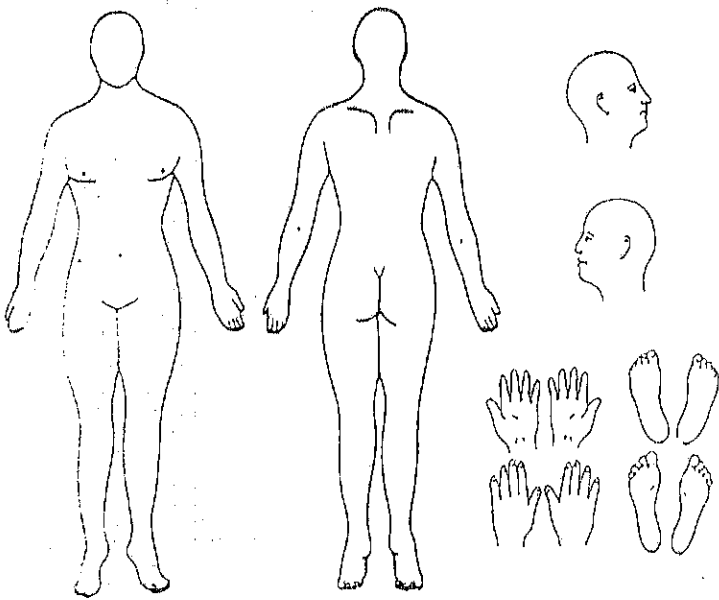
- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

EYES, EAR, NOSE AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Hearing loss
- Ear discharge
- Nose pain
- Nose bleeding
- Nose discharge
- Difficulty breathing thru nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech

NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscle jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression



Patient's Signature

*****DO NOT WRITE BELOW THIS LINE*****

Patient Accepted? Yes No Doctor's Signature _____

South Shore Chiropractic, P.C.

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Chiropractic Informed Consent To Treat

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, and/or other tests on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working, or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, falls, dizziness, headaches, burns with modalities and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Dr. Michael J. Campo

Dr. Jayesh Patel

Dr. Marc Avvento

Patient Signature (or patient representative)

Date

(indicate relationship if signing for patient) _____