NUZZI CHIROPRACTIC
LIFESTYLE WELLNESS CENTER

CASE HISTORY

Name _____Age _____Date _____

Address _____City _____ State___ Zip_____

Phone (Home) _____ (Cell) _____Date of Birth_____ Sex: M F

Occupation Employer _____ Phone (Work) _____

Email Address_____

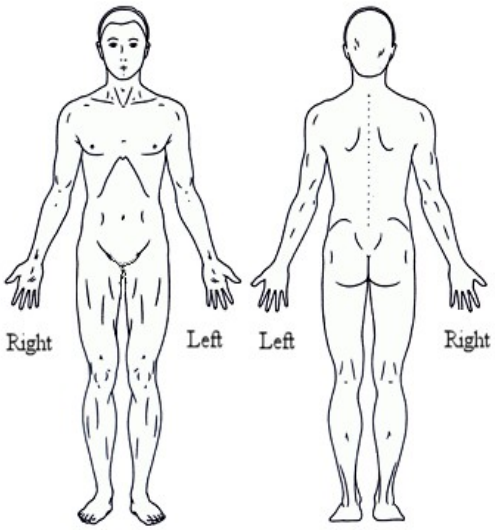
Emergency Contact: _____Phone_____

Current Weight _____Current Height_____

Primary Language _____Race_____Ethnicity_____

Referred by: _____

HEALTH REPORT
Reason for seeking care: _____
Present condition due to an injury? __ Yes __ No __ On the Job __ Auto Accident __ Other ____
Has the accident been reported? __ Yes __ No __ to; Employer __ Auto Carrier __ Other _____



Please circle degree of pain, 0 none, 10 severe pain.
0 1 2 3 4 5 6 7 8 9 10
Using the symbols below, mark on the pictures where you feel pain.
Numbness = =
Dull Ache OO
Burning XX
Sharp/Stabbing / /
Pins, Needles + +
Other_____
What activities aggravate your condition/pain? _____
What activities lessen your condition/pain? _____
Is this condition worse during certain times of the day? Y/N
Is this condition interfering with Work? _____
Sleep? _____ Routine? _____Other? _____

Is this condition progressively getting worse? _____

List any other doctors seen for this: _____

Name _____ **Date _____**

List any diagnosis and type of treatment: _____

Have you had similar accidents or injuries before? __ Yes __ No If yes, explain:
_____
_____

Have you received chiropractic treatment previously? __ Yes __ No

If yes, explain: _____

Have you been treated for any health condition by a physician in the last year? __ Yes __ No

If yes, explain: _____

Please list any allergies_____
_____
_____

Are you currently taking medication? __ Yes __ No _____

List current medications with dosage and frequency_____
_____
_____
_____
_____

List conditions you are taking medications for:
_____

List the approximate dates of any surgery or treated conditions: _____
_____

Family History: Health conditions, age of death and cause of death.

Father: _____

Mother: _____

Brother/s & Sister/s: _____

Do you smoke Y/N ____ Packs per week? _____ How long? _____

Alcohol Y/N __Daily __Weekly __Social Occasions Caffeinated drinks per day ____

Do you take Vitamins/Supplements Y/N If yes, type and how often
_____
_____
_____

Name _____ **Date** _____

Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS
__ Convulsions
__ Dizziness
__ Fainting
__ Headache
__ Nervousness
__ Numbness

MUSCLES & JOINTS
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains
__ Broken Bones

CARDIO-VASCULAR
__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Strokes
__ Swelling Ankles
__ Varicose Veins

EAR/NOSE/THROAT
__ Earache
__ Ear Noises
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis

GASTRO-INTESTINAL
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

RESPIRATORY
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES
__ Bruising Easily
__ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Allergy _____

FOR WOMEN ONLY
__ Birth Control _____
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain
Pregnant at this Time Y/N

Name _____ Date _____

Activities of Daily Living

Do you experience any pain while:

1.	Bending	Yes	No	Can't
2.	Caring for Children	Yes	No	Can't
3.	Carrying	Yes	No	Can't
4.	Climbing	Yes	No	Can't
5.	Dressing	Yes	No	Can't
6.	Driving	Yes	No	Can't
7.	Exercising	Yes	No	Can't
8.	Gardening	Yes	No	Can't
9.	Lifting	Yes	No	Can't
10.	Lying down or sleeping (please circle)	Yes	No	Can't
11.	Performing daily household chores	Yes	No	Can't
12.	Pushing or pulling (please circle)	Yes	No	Can't
13.	Rolling over in bed	Yes	No	Can't
14.	Running	Yes	No	can't
15.	Shoveling	Yes	No	Can't
16.	Sitting or sitting to standing (please circle)	Yes	No	Can't
17.	Standing	Yes	No	Can't
18.	Walking	Yes	No	Can't
19.	Watching TV	Yes	No	Can't
20.	Working or computer work (please circle)	Yes	No	Can't

Treatment Authorizations and Releases

Patient's Name: _____

Parent / Guardian's Name If Signing For Patient: _____

Consent for Treatment/ Payment Agreement
I, the undersigned, hereby authorize Dr. Lori A. Nuzzi (D.C.) and/or whomever she may designate as assistant(s) or covering physician(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that referrals from my primary care physician, when necessary, are entirely my responsibility and that if one is not obtained I will be expected to pay regardless of my insurance coverage. I understand and agree that if any payments due by me are not made in a timely manner (60 days from initial billing), I will be responsible for late charges, interest of 1 ½% per month, and any applicable collection fees as permitted by law. Furthermore, I understand that any amount authorized to be paid by my insurance will be paid directly to this office and credited to my account. I permit this office to endorse remittances for the conveyance of credit to my account. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME, AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

Patient's Signature: _____ Date / / Witness: _____

Authorization to Release Medical Information
I authorize Dr. Lori A. Nuzzi (D.C.) and/or whomever she may designate as assistant(s) or covering Physician to release any medical information pertinent to my treatment plan to my insurance company or an authorized representative for review. This authorization for release of information shall include any and all information necessary to process my insurance claims and remains valid indefinitely. I certify that all insurance information given to this office is correct and complete. I also know that I am entitled to receive a copy of this authorization form.

Patient's Signature: _____ Date: / / Witness: _____.

Request for Payment of Benefits to Provider of Care
I hereby irrevocably authorize my insurance company / insurance administrator to pay by check made out and mailed directly to: Dr. Lori A. Nuzzi, or Nuzzi Chiropractic Family & Sports Center, the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by the above named Doctor of Chiropractic to be released to any representative of their offices. I have agreed to pay, in a current manner, any balance of said applicable charges I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill. I authorize the office to act in my behalf and report any suspected violations of proper claims practices by my insurance company to the proper regulatory authorities.

Patient's Signature: _____ Date: / / Witness: _____

Consent for Treatment of Minor
I hereby authorize Dr. Lori A. Nuzzi (D.C.) and/or whomever she may designate as assistant(s) or covering physician(s), to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as she deems necessary to my: son/ daughter ,Name:_____

Parent/Guardian's Signature: _____ Date: / / Witness: _____

HIPAA Compliance
The office of Dr. Lori A. Nuzzi and its employees may use my health and personal information in any way necessary to obtain payment for services. This includes but is not limited to: filing claims, obtaining pre-authorizations, referrals, and billing outstanding balances. This information may also be shared with my other treating physicians or technicians as necessary. While every effort will be made to keep this information confidential, I understand that some information such as my name or a portion of my name may be used in the presence of others.

Patient's Signature: _____ Date: / / Witness: _____