. Dr. Scott Cabazolo, D.C.
Natural Results Chiropractic Clinic
112 East 6th Street #A, Front Royal, Va. 22655
540-622-6400

Today's Date: _____

Confidential Patient Health Record

How did you hear about us? **Family ___ Who_____ Friend ___ Who_____ Co-Worker __ Who_____**
Internet: _____Dr. _____ Yellow pages Drove by Hospital Insurance Plan

Personal Information

Last:_____ First:_____ Middle: _____ Suffix _____

Address _____ Apt or Suite _____

City: _____ State_____ Zip Code: _____

Birth Date: ____ /____/_____ Age:_____ Sex: Male / Female SS #: _____-_____-_____

Primary Language: English French German Spanish other: _____

Driver's License #: _____ State: _____ (Copy required)

Race: African American Asian Caucasian Hispanic Multiracial Native American Other: _____

Marital Status: Single Married Widowed Divorced Separated

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Cell Phone: (_____) _____-_____ Fax #: (_____) _____-_____

Email Address: _____ Spouse's Name: _____

Children (Names and Ages): _____

Ethnicity: American (White) __ American Indian__ Asian__ African American Other_____

Decline to answer__

Emergency Contact

Last: _____ First:_____ Middle: _____

Relationship: Spouse Relative Friend Other _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Work Phone: (_____) _____-_____ ext _____ Fax #: (_____) _____-_____

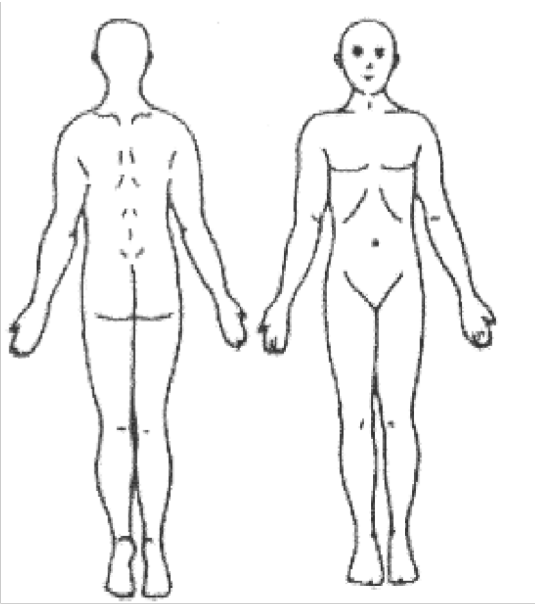
Your Employment Information
Business Name:
_____

Address: _____ City: _____
State: _____ Zip: _____ Phone: (_____) _____-_____ Fax #: (_____) _____-
_____ Occupation/Job Title: _____ Job description_____

Current Health Condition

Unwanted Condition (Why you are here today?):_____
Use the letters BELOW to indicate the TYPE and LOCATION of your sensations.

N = Numbness P=Pins & Needles S=Stabbing



When did this Condition BEGIN? _____/_____/_____

Has it ever occurred before? Yes No. When? _____

Is the Condition: Auto Related Job Related Home Injury

Slip or Fall Lifting Slept Wrong Unknown Cause Other

Explain: _____

_____

Date of Accident: _____ Time of Accident: _____ am /pm

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?

_____
_____

REVIEW OF SYSTEMS:

PLEASE LIST BELOW WHAT YOU HAVE OR HAVE HAD IN THE FOLLOWING:

SURGERIES: WHAT KIND

_____
_____
_____
_____

Ears, Nose and Throat:	**List any conditions you have or have had**

_____
_
_____
_
_____
_

Respritory: **List any conditions you have or have had**

_____

__

_____

__

_____

__

Cardiovascular: **List any conditions you have or have had**

_____

_____

_____

Gastrointestinal: **List any conditions you have or have had**

_____

_____

_____

I have or have had any of the symptoms or problems listed below.

NervousSystem:

dizziness limb weakness numbness slurred speech tremor facial weakness loss of consciousness seizures stress unsteadiness of gait/ loss of balance headache loss of memory sleep disturbance strokes

Allergy: **I have or have had any of the symptoms or problems listed below.**

anaphalaxis itching chronic nasal congestion food intolerance acute nasal congestion rash sneezing

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PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Previous Care for this Same Condition:

I have not previously seen a doctor for this condition OR Fill in the information BELOW

Have you seen other doctors for THIS CONDITION? Yes No. If yes, Who? (Name) _____

Type of Treatment: _____ Were you satisfied with the results of your treatment? Yes No

Explain: _____

Previous Chiropractic Care: **I have not previously seen a Chiropractor OR Fill in the information BELOW.**

Doctor's Name: _____ Location: _____ Date of Last Visit: _____

Were you satisfied with your care? Yes No. Why? _____

Do you wear any of the following? Heel Lifts Innersoles Arch Supports Orthotics Other_____
For how long? _____ Were they prescribed by a doctor? Yes or No.

Injury (ies):	**Mark or List All Injuries. Write the DATE of the Injury immediately afterward.**	
back injury	**head injury (loss of consciousness)**	**motor vehicle accident**
broken bones	**head injury (no loss of consciousness)**	**soft tissue injury (mild)**
disability (ies)	**industrial accident**	**soft tissue injury (moderate)**
fall (severe)	**joint injury**	**soft tissue injury (severe)**
fracture	**laceration (severe)**	**other:**

Alcohol: do not drink alcohol social consumption only drink the following regularly: beer liquor wine; quantity of _____ oz./glasses per day week month

My Dietary Intake consists mainly of the following: (mark all that apply)
high fat high salt low fiber high fiber
low calorie low salt high protein low carbohydrate
low sugar

Substance: never used illegal drugs has not used illegal drugs since _____ .
never used IV drugs used illegal drugs for _____ (how long?)

Tobacco: Do not use tobacco Do not smoke cigars, cigarettes or pipe Live with a smoker Quit smoking Smoke: # ____ per Day Week Month; Chew: #_____cans per Day Week Year

Insurance Information:

Who Is Responsible For Your Bill? **YOU and… (mark appropriate box(es)** **Myself ONLY**

Spouse Worker's Comp Auto Insurance Medicare Medicaid Other (be specific):_____

Personal Health Insurance Carrier: _____ **Health ID Card #: _____**

Policy Holder's Name: _____ **Group #: _____**

Policy Holder's Date of Birth _____ **Primary Care Physician: _____**

Workers Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? Yes No Date:____/____/_____Time: _____am/pm

Carrier: _____ **Policy # _____**

Carriers Phone #: (_____) _____-_____ **Adjuster: _____**

Claim #: _____

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I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable. I also understand that should my account require collection that I will be responsible for any and all collection costs.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Print Name: _____ Patient's Signature: _____ Date: _____
Consent to treat a Minor: _____ Date: _____
Guardian or Spouse's Signature of Authorizing Care: _____ Date: _____

I acknowledge that I have received the Chiropractic Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: _____ Date: _____
Patient's Signature: _____ Date: _____

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