Essential Healing Chiropractic

~ wholistic healthcare ~

Robert Ciafone D.C. FIAMA

105 Weatherstone Parkway
Suite 640
Woodstock, Ga 30188
770 592 5525

If you are tired of feeling "sick and tired" and want to be full of energy and vitality again, we can help you.

Dear New Patient,

Thank you for choosing Essential Healing Chiropractic for your health care needs.

My name is Dr. Robert Ciafone "Dr. Rob" and I am a chiropractor who specializes in Neurological Integration System (NIS). I am looking forward to helping you reach your health care goals. In order for us to get started, you just need to print this paperwork, fill it out, and bring it with you to your first appointment. Please Do Not email the forms back to us. Please take the time to fill them out in as much detail as you can provide. This information is very important to me in helping to determine the best strategy in helping you reach your health goals. **Please arrive 15 minutes before your scheduled appointment time with your paperwork already filled out**. This will allow us to start on time and give you the best possible experience in our office. Please feel free to call us at 770-592-5525 if you have any questions.

We are looking forward to helping you "Get out of Stress with NIS"

Dr. Rob

Office hours:

Monday	closed	
Tuesday, Wednesday, Thursday		8:30am to 7:00pm
Friday	8:30am to 3:00pm	
Saturday	8:30am to 3:00pm	

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About You

Name:_____ **Date:**_____

Address:_____ **Apt#**_____ **City:**_____ **St:**_____ **Zip:**_____

Home Phone #:_____ **Work Phone#:**_____ **Cell #:**_____

E-Mail:_____

Employer:_____ **Occupation:**_____

Sex: M F | Marital Status: S M D W | Age:_____ **Date of Birth** _____/_____/_____

Spouses Name:_____ **Employer:**_____ **Cell Phone#:**_____

Who may we thank for referring you to our office?_____

Reason for Visit

Reason for today's visit: __ emergency __ new injury __ old injury __ chronic pain __ wellness

When did your accident occur?_____ **Where did your accident occur?**_____

Please explain what happened_____

Did your injury occur during: __ work __ sports/play __ auto accident __ routine/household activity

Are you in pain? __ yes __ no Rate your pain on the following scale: discomfort 1 2 3 4 5 6 7 8 9 10 intense

Describe the pain: __ sharp __ stabbing __ throbbing __ burning/searing __ aching __ numb/tingling

Does the pain radiate? __ yes __ no If yes, to where:_____

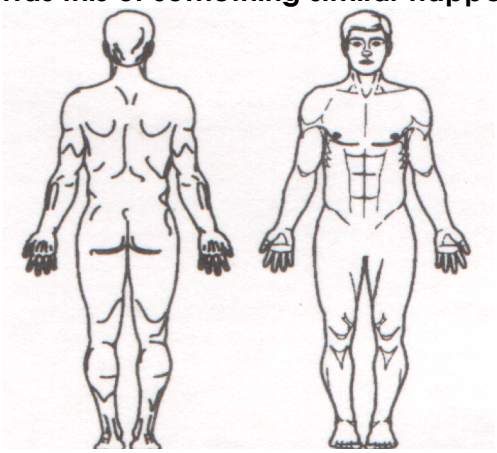
Is there anything that makes it feel better? __ rest __ motion __ changing positions __ ice/heat __ meds

Is there anything that makes it feel worse? __ standing __ lying __ sitting __motion __ rest __ice/heat

Is your condition getting worse? __ yes __ no __ constant __ comes and goes

Is your condition interfering with? __ sleep __ work __ play __family life __ daily routine

Has this or something similar happened in the past? __ yes __ no Explain:_____



Using the adjacent body charts, please circle all affected areas

Have you been treated by any other professionals for this condition?
__ yes __ no

If yes, where?_____
_____
_____

Health History

Please check any of the following that apply:

CHILDHOOD HISTORY

__ Hospital birth
__ Broken bones
__ Breastfed
__ Surgeries
__ Falls/accidents
__ Illnesses
__ Played sports
__ ADD/ADHD

ADULT HISTORY

__ Accidents
__ Joint replacements
__ Organ Transplant
__ Epilepsy
__ Alzheimer's
__ Osteoarthritis
__ Venereal Disease
__ Mono/EBV
__ Surgeries
__ Stroke/TIA
__ Aids/HIV+
__ Multiple Sclerosis
__ Autoimmune Disease
__ Rheumatoid Arthritis
__ Tuberculosis
__ Shingles
__ Illnesses
__ Pacemaker/Electrical implant
__ Anemia
__ Parkinson's
__ Diabetes
__ Scoliosis
__ Rheumatic Fever
__ Herpes
__ Broken bones
__ Metal implants
__ Cancer
__ Dementia
__ Hypoglycemia
__ Heart Disease
__ Polio
__ Lupus

MUSCULOSKELETAL

NECK
__ Pain in the neck
__ Neck pain with movement
__ Stiff neck
__ Muscle spasm
__ Head feels heavy

SHOULDERS
__ Pain in the shoulders (L-R)
__ Pain between the shoulders
__ Tension in the shoulders
__ Pain with movement (L-R)
__ Can't raise arm (L-R)

ARMS & HANDS
__ Pain in the upper arm (L-R)
__ Pain in the lower arm (L-R)
__ Pain in the wrist/hand/finger
__ Numbness or tingling
__ Elbow pain

BACK
__ Low back pain
__ Low back feels out of place
__ Sciatica
__ Muscle spasms
__ Loss of range of motion
__ Worse with stress

HIPS, LEGS and FEET
__ Hip pain
__ Pain in the buttocks
__ Pain down the leg
__ Pain with movement (L-R)
__ Leg cramps
__ Knee pain

__ Foot pain
__ Flat feet
__ Cold feet
__ Numbness or tingling
__ Heel pain
__ Burning pain in arches

Family History

Please list any illnesses, age (if living), age at death (if deceased) and cause of death

Mother _____

Father _____

Siblings _____

Maternal Grandparents _____

Paternal Grandparents _____

Please list any surgeries with dates and / or any other serious medical conditions not listed above:

_____

List any past serious accidents with dates:_____

Date of last physical exam:_____ **Reason:**_____

Please list any medications or nutritional supplements you are currently taking and why: _____

_____

***Females only*: Are you taking birth control?** __ yes __ no **Are you pregnant?** __ yes __ no

Are you nursing? __ yes __ no **Hysterectomy?** __ yes __ no

Patient Questionnaire

Any old injuries that still bother you today?_____

When was the last time you felt well?_____**Did something trigger your change in health?**_____

Please underline or circle any of the following symptoms that you have experienced in the last 30 days

Head – Headaches, Migraines, Pressure, Dizziness/Vertigo, Loss of balance?

Eyes – Glasses, Contacts, Dry eyes, Irritated eyes, Sore eyes, Burning, Cataracts, Astigmatism, Glaucoma?

Ears – Poor hearing, Hearing aids, Ringing, Infections, Itching, Balance problems?

Nose – Poor sense of smell, Nosebleeds, Runny nose, Dry nasal passages, Snoring, Sleep apnea?

Mouth – Mercury fillings, Implants, Dentures, TMJ dysfunction, Clenching, Grinding the teeth, Braces?

Nails – Ridges, Cracks, Brittle, Splitting, Poor growth, White spots?

Cardiovascular – Palpitations, Fast Pulse, High or low blood pressure, Shortness of breath, Chest pain?

Respiratory – Asthma, Cough, Wheezing, Difficulty breathing, Mucus, Sinus pressure?

Urinary – Frequent urination, Loss of control, Burning, Kidney stones, Other?_____

Digestion – Burping, Heartburn, Bloating, Nausea, Vomiting, Diarrhea, Constipation, Gas, Mucus, Blood, Ulcers, IBS, Candida, Gall bladder attacks, Other?_____

Endocrine – Tired in the morning, Tired in the afternoon, Weight gain, Slow metabolism, Hair falling out, Outer third of eyebrow thins, Heart palpitations, Anxiety, Inward trembling, Frequent thirst?

Males only – Urination difficulty or dribbling, Frequent urination, Decrease in libido, Decrease in fullness of erections, Episodes of depression, Spells of mental fatigue, Decrease in physical stamina?

Females only – Perimenopausal, Menopause, Extended menstrual cycle (over 32 days), Shortened menstrual cycle (under 24 days), Scanty blood flow, Heavy blood flow, Symptoms worse during second half of cycle, Breast pain and swelling during menses, Acne, Facial hair growth, Ovarian cysts, Other?_____

On average, what time do you go to sleep?_____**Do you have a hard time falling asleep?** Yes No

On average, what time do you wake up?_____ **Do you have a hard time waking up?** Yes No

Do you feel rested in the morning? Yes No **Rate your sleep quality** Great Good Fair Poor

Do you sleep through the night? Yes No **If no, what time(s) do you wake up?**_____

What foods do you crave?_____

Do you have any food allergies?_____

Do you have any allergies to vitamins, herbs or nutritional supplements?_____

General energy levels? High Low **Do you feel better in?** The morning The evening

Stress Level? High Low **Is your stress related to?** Work Home Finances Other_____

What do you hope to achieve in your care with us?_____

Is there anything else you would like to discuss with the doctor?_____

_____

_____

Consent for examination

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment.
- The statements made on this form and attached forms are accurate to the best of my recollection, and I understand it is my responsibility to inform this office of any changes to the information I have provided

Signature_____ **Date**_____

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Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Our only goal is to help your nervous system restore all of the signals to all of your cells. We do not offer to diagnose or treat any disease or condition. However, if during the course of your examination or treatment, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advise, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

I understand that NIS is considered an elective procedure by insurance companies, therefore I will not be provided an insurance receipt to send to my insurance company including Medicare, nor will I ask my insurance company to be billed for services that are provided by Essential Healing Chiropractic, which have no billable insurance code. I understand that I am solely responsible for all charges for services provided to me by Essential Healing Chiropractic. Upon request, we can provide you with a statement at the end of the year for tax purposes only.

I hereby request and consent to the performance of NIS, chiropractic adjustments, other chiropractic procedures on me by the doctor of chiropractic named below and/or anyone authorized by the same doctor. I further understand and am informed that, as in all health care, there are some slight risks to and do not expect the doctor to be able to anticipate or explain all risks. 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, is in my best interest. I have read the consent and intend this consent form to cover the entire course of my care for this condition and any care in the future.

I, _____ have read and fully understand the above statements.
(print name)
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis. (signature)_____ Date_____

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her partners have permission to perform an evaluation. Date of last menstrual period:_____

_____ Date_____
(signature)

Missed Appointments:

Our cancellation policy is as follows. We ask that you kindly give us 24 hours notice if you are unable to keep your appointment. This gives us the necessary time to reschedule your appointment and schedule another patient in need of treatment in your place. With the first missed appointment, we will kindly remind you to give us 24 hours notice for future cancellations to avoid being charged a fee. With the second missed appointment, there will be a $25 fee. With the third missed appointment, the fee will be based on the full price of the visit time scheduled. The forth missed appointment will result in termination of care. We are very understanding and know that life throws us unexpected situations, and we will do our best to accommodate you.

_____ Date_____
(signature)

Financial Policy:

Payment is expected when services are rendered, unless previous arrangements have been made. We accept cash, checks, Visa, Discover, MasterCard, American Express and Debit cards. There will be a $25 fee for any returned checks. There is a fee charged for any reports required by any third-party members.

_____ Date_____
(signature)

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Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Appointment reminders and private health information will be communicated to you only in the manners in which you have given specific written authorization and you have the option to opt out of any of those methods at any time by notifying our office. Email and standard SMS/text messaging are not confidential methods of communication and may be insecure.

I, _____, hereby consent and state my preference to have my chiropractor, Dr. Robert Ciafone, and other staff at Essential Healing Chiropractic communicate with me by email or standard SMS/text messaging, in addition to or to replace leaving phone messages, regarding various aspects of my health care, which may include, but shall not be limited to, test results, appointments, and billing. I understand that email and standard SMS/text messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS/text messaging regarding my medical care might be intercepted and read by a third party.

Appointment reminders are only made if verbally requested by you.

I give my permission to leave both appointment reminders AND my private health information at the following (please fill-in the ones you agree to):

Phone number_____

Email_____

Text_____

I give permission to contact me, relative to appointment reminders only, by the following methods:
Phone message at the following number_____

Email messages at the following email address_____

Text messages at the following phone number_____