

# MARUCCI CHIROPRACTIC & WELLNESS CENTER

## CONFIDENTIAL PATIENT CASE HISTORY

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis and determining the source of your problem. Please take the time and answer each question as completely as possible.

### PATIENT INFORMATION\*\*\*\*\*

FIRST NAME: \_\_\_\_\_ LAST NAME: \_\_\_\_\_ MIDDLE INT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ CELL PHONE: (\_\_\_\_) \_\_\_\_\_ GENDER: MALE FEMALE

AGE: \_\_\_\_\_ BIRTH DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ SOC. SEC#: \_\_\_\_/\_\_\_\_/\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

EMAIL: \_\_\_\_\_ MARITAL STATUS: M / S / D / W # OF CHILDREN: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_ WORK#: (\_\_\_\_) \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_ SPOUSE'S EMPLOYER: \_\_\_\_\_ WORK#: \_\_\_\_\_

NAME OF PERSON WHO REFERRED YOU: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_ ADDRESS: \_\_\_\_\_ PHONE#: \_\_\_\_\_

FAMILY DENTIST: \_\_\_\_\_ ADDRESS: \_\_\_\_\_ PHONE#: \_\_\_\_\_

### HEALTH INFORMATION\*\*\*\*\*

**WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?**  
(PLEASE LIST IN ORDER OF IMPORTANCE WITH 1 BEING MOST IMPORTANT)

1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_

WHEN DID THIS PROBLEM START? \_\_\_\_\_



WHAT CAUSED THE PROBLEM? \_\_\_\_\_

IF YOU WERE INJURED WAS IT:	DID YOUR PAIN COME ON:	ARE YOU ABLE TO:	YES	NO
<input type="checkbox"/> AT HOME	<input type="checkbox"/> SUDDENLY <input type="checkbox"/> GRADUALLY	SLEEP NORMALLY	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> AT WORK		DO DAILY ACTIVITIES	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> AUTO ACCIDENT	IS THE PAIN	CARE FOR YOURSELF	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> OTHER PERSONAL INJURY	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	FUNCTION NORMALLY	<input type="checkbox"/>	<input type="checkbox"/>

Have you had this problem before?  YES  NO When? \_\_\_\_\_

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Who treated your last occurrence?

PHYSICIAN	SPECIALTY	TREATMENT DATES
		

ON THE FIGURES AT THE RIGHT,  
PLEASE MARK YOUR AREA(S) OF  
PAIN OR DISCOMFORT

+++ Burning /// Stabbing  
\*\*\*\* Pins & needles xxx No feeling  
Circle the areas (if more than one) of pain  
and tell us on a scale of 1 to 10, with 1  
being light pain to 10 being very severe,  
how severe is your pain in each area most  
of the time.



AREA 1 pain is (1-10) \_\_\_\_\_  
AREA 2 pain is (1-10) \_\_\_\_\_  
AREA 3 pain is (1-10) \_\_\_\_\_

Which words describes your pain MOST of the time?

<input type="checkbox"/> Constant	<input type="checkbox"/> Tingling
<input type="checkbox"/> On and Off	<input type="checkbox"/> Burning
<input type="checkbox"/> Occasional	<input type="checkbox"/> Throbbing
<input type="checkbox"/> Only at night	<input type="checkbox"/> Deep, stabbing
<input type="checkbox"/> Only on exertion	<input type="checkbox"/> Deep Achy
<input type="checkbox"/> Dull Ache	<input type="checkbox"/> Sharp recurring pain

How would you describe your current mobility?

<input type="checkbox"/> Self Mobile	<input type="checkbox"/> Need Walker
<input type="checkbox"/> Need cane	<input type="checkbox"/> Need wheelchair

Which best describes your current employment?

<input type="checkbox"/> Working	<input type="checkbox"/> Full time	<input type="checkbox"/> Part time
<input type="checkbox"/> Unemployed		
<input type="checkbox"/> On sick leave		
<input type="checkbox"/> On temporary disability		
<input type="checkbox"/> On permanent disability		
<input type="checkbox"/> Retired		

If on temporary or permanent disability or sick leave  
Last full day of work was \_\_\_\_\_

IF YOU PREVIOUSLY HAD ANY OF THE FOLLOWING PROCEDURES, PLEASE LIST THE DATA AND PLACE THEY WERE PERFORMED

PROCEDURE	DATE	PLACE PERFORMED
X-RAYS		
CT/MRI		
MYELOGRAM		
ULTRASOUND		
EMG		

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PLEASE INDICATE ALL THERAPIES PREVIOUSLY USED TO TREAT YOUR CONDITION, WHERE GIVEN AND THE AMOUNT OF RELIEF OBTAINED.

PROCEDURE/THERAPY	PERFORMED BY OR DESCRIPTION OF THERAPY	RELIEF OBTAINED
PAIN MANAGEMENT		
EPIDURAL		
SURGERY		
PHYSICAL THERAPY		
CHIROPRACTIC		
MASSAGE THERAPY		
ACUPUNCTURE		
SPINAL DECOMPRESSION		
TAI CHI		
HERBAL OR HOMEOPATHIC		
TENS UNIT		
HOME TRACTION UNIT		
OTHER		

Have you undergone any psychological counseling for chronic pain or depression?  Yes  No

If Yes, when and where? \_\_\_\_\_

Have you undergone any surgical procedures, including nerve blocks to relieve your pain?  Yes  No

If Yes, when, where and how much relief did they provide? \_\_\_\_\_

PREVIOUS MEDICATIONS PLEASE LIST ALL MEDICATIONS THAT DO NOT HELP NAME OF MEDICATION, STRENGTH, DAILY DOSE

WHAT MEDICATIONS OR TREATMENT, THAT YOU ARE NOT CURRENTLY ON, IF ANY, SEEMED TO HELP YOUR PAIN IN THE PAST. PLEASE LIST BY NAME AND GIVE THE FREQUENCY THAT HELPED THE MOST

CURRENT MEDICATIONS PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING. (Prescriptions and over-the-counter). Name of medication and Strength #of doses / day

HOSPITALIZATION and SURGERY PLEASE LIST ALL SURGERY AND ANY PERIODS OF HOSPITALIZATION (give dates)

LIST ANY MEDICATIONS THAT HAVE CAUSED AN ALLERGIC REACTION: \_\_\_\_\_

DO YOU HAVE IMPLANTS?  Yes  No      PACEMAKER?  Yes  No      DEFIBRILLATOR?  Yes  No

DO YOU NOW OR HAVE YOU EVER: (This is confidential information we need to treat you properly)

Smoke?  Yes  No     Stopped When? \_\_\_\_\_    Packs per day? \_\_\_\_\_

Use Alcohol?  Yes  No      Type and Amount? \_\_\_\_\_

Drink coffee/caffeine?  Yes  No      Type and Amount? \_\_\_\_\_

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Use recreational drugs?  Yes  No      Type and frequency? \_\_\_\_\_

Been addicted to any drug?  Yes  No      Type and how long? \_\_\_\_\_

PLEASE MARK ANY CONDITION THAT YOU NOW HAVE OR HAVE RECOVERED FROM IN THE PAST			
SEVERE HEADACHES	CHEST PAIN/ANGINA	KIDNEY STONES	DIGESTIVE PROBLEMS
HYPERTENSION	HEART PALPITATIONS	RENAL DISEASE	GOUT
STROKE	HEART MURMUR	DIABETES	ARTHRITIS
EPILEPSY	ARRHYTHMIA	ENDOCRINE DISEASE	HIV/AIDS
FATIGUE	CONGENITAL HEART DISEASE	URINARY OR GENITAL PROBLEMS	CLAUDICATION
DIZZINESS/FAINTING	RHEUMATIC OR SCARLET FEVER	PROSTATE PROBLEMS	ULCER
ANEMIA	GALL STONES	SEXUAL DYSFUNCTION	VENEREAL DISEASE
SHORTNESS OF BREATH	PANCREATITIS	MENSTRUAL DYSFUNCTION	MENTAL ILLNESS
ASTHMA	LIVER DISEASE	OVARIAN CYSTS	ALCOHOL OR DRUG PROBLEMS

**Women Only** Can you become pregnant?  Yes  No

If not, why? \_\_\_\_\_

Date of last period \_\_\_\_\_ Normal?  Yes  No

Are you now or could you be pregnant?       Yes  No

Please provide the date or approximate date of your last:

Mammogram \_\_\_\_\_

Pap Smear \_\_\_\_\_

## FAMILY HEALTH INFORMATION\*\*\*\*\*

(MANY HEALTH PROBLEMS ARE THE RESULT OF HEREDITARY CONDITIONS; THIS INFORMATION ABOUT YOUR FAMILY MEMBERS WILL GIVE US A BETTER PICTURE OF YOUR TOTAL HEALTH)

Number of people living in your household? \_\_\_\_\_

Do you have stairs in your residence that you must climb?  Yes  No

Are you able to take medication by yourself?  Yes  No

Are you able to feed and bath yourself?  Yes  No

Do you require any special care or have any other concerns that might affect your treatment or recovery?  Yes  No

If yes please describe: \_\_\_\_\_

\_\_\_\_\_

FAMILY HISTORY: Has anyone in your immediate family (father, mother, grandparents, brothers, sisters, children) had;			
CONDITION	WHO?	CONDITION	WHO?
HEART DISEASE		EPILEPSY	
HYPERTENSION		GLAUCOMA	
STROKE		BLEEDING DISORDER	
CANCER		KIDNEY DISEASE	
DIABETES		THYROID DISEASE	

## ACCIDENT INFORMATION\*\*\*\*\*

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IF YOU WERE INVOLVED IN AN ACCIDENT OR A TRAUMATIC INCIDENT, COMPLETE THIS SECTION

DATE OF ACCIDENT: \_\_\_\_\_

BRIEFLY DESCRIBE THE ACCIDENT: \_\_\_\_\_

\_\_\_\_\_

DESTINATION AFTER ACCIDENT / INJURY: \_\_\_\_\_

WERE YOU HOSPITALIZED:  YES  NO HOSPITAL NAME: \_\_\_\_\_

WERE X-RAYS TAKEN:  YES  NO IF YES, RESULTS: \_\_\_\_\_

HAS DOCTOR OR DENTIST EVER DIAGNOSED A TMJ DISORDER PRIOR TO THE ACCIDENT:  YES  NO

## INSURANCE INFORMATION\*\*\*\*\*

### HEALTH INSURANCE:

SUBSCRIBER NAME / NUMBER: \_\_\_\_\_

SUBSCRIBER SOCIAL SECURITY NUMBER: \_\_\_\_\_ SUBSCRIBER DATE OF BIRTH \_\_\_\_\_

GROUP NUMBER: \_\_\_\_\_ POLICY NUMBER: \_\_\_\_\_

EXPIRATION DATE: \_\_\_\_\_

### SECONDARY HEALTH INSURANCE:

SUBSCRIBER SOCIAL SECURITY NUMBER: \_\_\_\_\_ SUBSCRIBER DATE OF BIRTH \_\_\_\_\_

SUBSCRIBER NAME / NUMBER: \_\_\_\_\_

GROUP NUMBER: \_\_\_\_\_ POLICY NUMBER: \_\_\_\_\_

EXPIRATION DATE: \_\_\_\_\_

### AUTOMOBILE INSURANCE:

NAME OF INSURED: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ CLAIM NUMBER: \_\_\_\_\_

NAME OF ADJUSTER: \_\_\_\_\_

IF YOU DO NOT HAVE YOUR OWN INSURANCE, DO YOU LIVE WITH ANY ONE THAT DOES:  YES  NO

NAME OF INSURED: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ CLAIM NUMBER: \_\_\_\_\_

NAME OF ADJUSTER: \_\_\_\_\_

## ATTORNEY INFORMATION\*\*\*\*\*

NAME OF ATTORNEY: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

ATTORNEY ADDRESS: \_\_\_\_\_

I authorize the release of a full report of examination findings, diagnosis, treatment program, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for

PATIENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_ 5

PRINT NAME: \_\_\_\_\_

# MARUCCI CHIROPRACTIC & WELLNESS CENTER

legal documentation to process claims. I understand that I am responsible for all charges for the treatment rendered to me regardless of insurance coverage.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that *Wellness Ventures, LLC / Jason T. Marucci, DC* 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 *Wellness Ventures, LLC / Jason T. Marucci, DC* will be credited to my account on receipt. 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. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

PATIENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_ 6

PRINT NAME: \_\_\_\_\_

# MARUCCI CHIROPRACTIC & WELLNESS CENTER

## CONSENT TO TREAT

I hereby authorize your practice and whomever you may designate to perform examination, physiotherapy, physical therapy and perform non-invasive diagnostic tests and, if any unforeseen condition arises in the course of the procedures calling for judgment, procedures in addition to or different from those non complicated. I further request and authorize this office to perform whatever your practice deems advisable. The nature and purpose of these procedures have risks involved and the possibility of complications has been fully explained to me. I acknowledge that no guarantee has been made to me as the result that may be obtained.

## AUTHORIZATION FOR MEDICAL INFORMATION

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, x-ray and physical findings diagnosis and prognosis. You are authorized to provide this information in accordance with the automobile personal injury protection law (Chapter 71-252F.S.).

## HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the Wellness Ventures, LLC / Jason T. Marucci, DC / David J. Denton, DPT provides you a copy of, or access to, our *Notice of Privacy Practices* which is printed on this clipboard.

I acknowledge that I have been presented the opportunity to read the Wellness Ventures, LLC / Jason T. Marucci, DC / David J. Denton, DPT Notice of Privacy Practices.

## ASSIGNMENT OF BENEFITS

Assignment of benefits defined as the medical benefits otherwise payable to me for their services, but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to WELLNESS VENTURES, LLC any right and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in OHIO Statutes for any service and or charges provided by WELLNESS VENTURES, LLC A photocopy of this document shall be sufficient.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that *Wellness Ventures, LLC* 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 *Wellness Ventures, LLC* will be credited to my account on receipt. 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. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

## LETTER OF NO ACCIDENT OR INJURY

I hereby state with my signature that I was not involved in any auto accident, slip & fall, or work injury. My treatment is in no way associated with any 3<sup>rd</sup> party, and no other party is responsible or liable for the cost of my treatment.

**I have not** been treated for this condition by a Chiropractor nor had any Physical therapy since January of this year.

**I have** been treated for this condition by a Chiropractor or had any Physical therapy since January of this year.

PATIENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_ 7

PRINT NAME: \_\_\_\_\_

