

Patient Information

Today's Date: \_\_\_\_\_

**Personal Information**

Name: \_\_\_\_\_  
\*LAST \*FIRST \*M.I.

Address: \_\_\_\_\_  
\*STREET ADDRESS APARTMENT/UNIT #  
 \_\_\_\_\_  
\*CITY \*STATE \*ZIP CODE

Phone Number:     (    )     Alternate Phone Number:     (    )    

Social Security Number: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Sex: M F Occupation: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

How did you hear about Cavallo Chiropractic? \_\_\_\_\_

**Insurance Information**

Will you be using insurance to help cover your chiropractic care? Y N If no, please skip to the next section.

Is your visit today due to an auto or work related injury? Y N

Insurance Company Name: \_\_\_\_\_ Claim or Member ID Number: \_\_\_\_\_

Patient's Relationship to Insured: Self Spouse Child Other: \_\_\_\_\_

\*\*\*If self insured:

Name of Employer or School: \_\_\_\_\_

Employer or School Address: \_\_\_\_\_  
\*STREET ADDRESS \*SUITE/UNIT #  
 \_\_\_\_\_  
\*CITY \*STATE \*ZIP CODE

\*\*\*If NOT self insured:

Name of Spouse/Parent/Other: \_\_\_\_\_ Insured's Birth Date: \_\_\_\_\_

Insured's Phone Number:     (    )     Insured's Alternate Phone Number:     (    )    

Employer Address: \_\_\_\_\_  
\*STREET ADDRESS \*SUITE/UNIT #  
 \_\_\_\_\_  
\*CITY \*STATE \*ZIP CODE

**Medical History**

Are you currently under a medical physician's care? Y N Physician's Name: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Have you ever been in a car accident? Y N If yes, when? \_\_\_\_\_

Have you ever been to a chiropractor before? Y N

Do you smoke? Y N If yes, how much? \_\_\_\_\_  
Do you drink? Y N If yes, how much? \_\_\_\_\_

Date of last menstrual period: \_\_\_\_\_ Are you currently pregnant? Y N

Are you currently experiencing or have you ever had the following conditions? (Please check those that apply.)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Impaired Hearing             | <input type="checkbox"/> Seizures/Epilepsy     | <input type="checkbox"/> Bleeding Disorders  |
| <input type="checkbox"/> Ringing in Ears              | <input type="checkbox"/> Paralysis             | <input type="checkbox"/> Anemia              |
| <input type="checkbox"/> Impaired Vision              | <input type="checkbox"/> Numbness in Arms/Legs | <input type="checkbox"/> Chicken Pox         |
| <input type="checkbox"/> Headaches                    | <input type="checkbox"/> Muscle Weakness       | <input type="checkbox"/> Measles             |
| <input type="checkbox"/> Shortness of Breath          | <input type="checkbox"/> Difficulty Breathing  | <input type="checkbox"/> Rubella             |
| <input type="checkbox"/> Palpitations                 | <input type="checkbox"/> Anxiety               | <input type="checkbox"/> Depression          |
| <input type="checkbox"/> Chest Pains                  | <input type="checkbox"/> Loss of Appetite      | <input type="checkbox"/> Insomnia            |
| <input type="checkbox"/> Persistent Cough             | <input type="checkbox"/> Fever                 | <input type="checkbox"/> Cancer              |
| <input type="checkbox"/> Thyroid Problems             | <input type="checkbox"/> Night Sweats          | <input type="checkbox"/> HIV                 |
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> General Fatigue       | <input type="checkbox"/> AIDS                |
| <input type="checkbox"/> Swelling of Ankles           | <input type="checkbox"/> Bloody Stools         | <input type="checkbox"/> Hepatitis           |
| <input type="checkbox"/> Nausea/Vomiting              | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Arthritis           |
| <input type="checkbox"/> Stomach Ulcers               | <input type="checkbox"/> Pneumonia             | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Difficulty Swallowing        | <input type="checkbox"/> Persistent Diarrhea   | <input type="checkbox"/> Rheumatic Fever     |
| <input type="checkbox"/> Constipation                 | <input type="checkbox"/> Dizziness             | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Difficult/Painful Urination  | <input type="checkbox"/> Fainting Spells       | <input type="checkbox"/> Kidney Disease      |
| <input type="checkbox"/> Urgent/Frequent Urination    | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Gallbladder Disease |
| <input type="checkbox"/> Significant Weight Loss/Gain |  |  |

What is the reason for today's visit? \_\_\_\_\_

Rate your overall pain today:      0      1 2      3 4      5 6      7 8      9 10  
   Pain      Mild      Uncomfortable      Moderate      Intense      Unbearable

**Certifications**

I certify the above information to be true and accurate to the best of my knowledge. I also hereby authorize payment of medical benefits for services provided by Cavallo Chiropractic. I also authorize Cavallo Chiropractic to release information regarding my injury/illness to my referring physician, attorney, and insurance company.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
[If patient is a minor.]

## Informed Consent

The law requires us to obtain your informed consent prior to examination and treatment. By signing this document, you are confirming that you have read and/or the doctor has discussed with you the following information; you have had an opportunity to ask questions and all of your questions have been answered fully and satisfactory.

**Treatment** - An adjustment is performed by the doctor by using his hands or a mechanical device on your body in such a way to move your joints. This procedure may cause an audible “click,” much as you may have experienced when you “crack” your knuckles. There are some material risks involved in doing this and they are as follows:

**Pain:** Most patients come into this office in pain. Rarely will treatment even temporarily increase soreness in the region being treated. However, since it is possible, I am including it in this section.

**Rib Fractures:** It is possible to “crack” an arthritic rib with an adjustment; this can happen with anyone. It occurs most often on aging patients that have weakened bones from osteoporosis. Osteoporosis is suspected with age, and can be noted on your x-rays. However, these problems occur so rarely that I have not been able to find available statistics to quantify their probability.

**Disc Herniation:** Occasionally, treatment will aggravate or cause a problem if the disc is in a weakened state. These problems occur so rarely that I have not been able to find available statistics to quantify their probability.

**Physical Therapy:** Some of the machines that we use generate heat. We also use ice in this office. Burns can possibly come from such treatment. If you have a pace maker or metal in your body, please notify the doctor prior to therapy. These problems occur so rarely that I have not found any statistics to quantify its probability.

**Stroke:** Strokes are not that common, and even less so in a chiropractic office. They are so rare that you have a greater chance of being hit by lightning (more than one in a million). This office reduces your odds even further through screening test during the examination.

**Other Problems:** There may be other problems or complications that might arise from treatment; other treatment such as massage, traction, etc. can be prescribed as a result. These other problems or complications are so infrequent, that it is not plausible to anticipate and/or explain them in advance of your treatment.

**Non-Treatment:** Remaining untreated or non-compliance can result in adhesions, pain and reduction in associated joint mobility. The probability that these adhesions and pain will interfere with motion, function and quality of life is almost certain.

**I hereby state that I have read, or have had read to me, and fully understand this consent form. I authorize and direct Dr. Louis J. Cavallo and his assistants to provide such additional services as they deem reasonable and necessary.**

Patients Printed Full Name: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature [If patient is a minor.]: \_\_\_\_\_

Witness' Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## HIPAA Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

### 1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Your protected health information may also be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Opportunities:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the reception desk where you will be asked to sign in for your appointment. We may also call you by name in the waiting room when your physician is ready to see you. We may also use or disclose your protected health information, as necessary, to contact you to remind you of your appointment or to reschedule a missed appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, Public Health issues; as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation Research; Criminal Activity; Military Activity and National Security; Worker’s Compensation; Inmates; Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

