Welcome To

Venti Chiropractic
& Sports Health

Patient Information

Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Email: _____

Sex: ❑ Male ❑ Female Date of Birth: _____ ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Minor

Occupation: _____ Employer/School: _____

Spouse/Parent's Name: _____ Children's Names/Age: _____

Person to contact in case of emergency: _____ Phone: _____

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

Responsible Party

Person responsible for this account: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Information

Name of Insured: _____ Relationship to patient: _____

Insured's DOB: _____ Insured's Social Security #: _____

Name of Employer: _____ Address: _____

City: _____ State: _____ Zip: _____

Insurance Co: _____ Phone: _____ Group #: _____ ID#: _____

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

Symptoms

Reason(s) for visit: _____

When did you first notice your symptoms: _____

Is it getting worse? _____

What **aggravates your pain**? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying down
❑ Lifting Objects ❑ Sleeping ❑ Working out ❑ Other _____

What, if anything, **relieves your pain**? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying down
❑ Lifting Objects ❑ Sleeping ❑ Stretching ❑ Ice ❑ Heat ❑ Other _____

	DULL	ACHING	SHARP	NUMB	BURNING	SHOOTING	TINGLING	CRAMPING	THROBBING	STIFF	RADIATING	Circle Severity of Pain 1 = Barely, 10= Severe									
EXAMPLE: LOW BACK			X			X						1	2	3	4	5	6	7	8	9	10
												1	2	3	4	5	6	7	8	9	10
												1	2	3	4	5	6	7	8	9	10
												1	2	3	4	5	6	7	8	9	10
												1	2	3	4	5	6	7	8	9	10
												1	2	3	4	5	6	7	8	9	10
												1	2	3	4	5	6	7	8	9	10
												1	2	3	4	5	6	7	8	9	10

Is/Are the pain(s) constant or does it come and go? ____________________

Has this problem been treated before? __________ If yes, how has it been treated and by whom? ____________________.

Personal (Circle all that apply to YOU)

AIDS/HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthritis	Depression	Heart Disease
Breast Lump	Bronchitis	Bulimia	Cancer	Fibromyalgia	Chicken Pox	Gout	Measles
Emphysema	Epilepsy	Fractures	Glaucoma	Cataracts	Gonorrhea	Liver Disease	Parkinson's
Hepatitis	Hernia	Herniated Disc	Herpes	Goiter	Kidney Disease	Pacemaker	Thyroid
Headaches	Miscarriage	Mono	M.S.	High Chol	Osteoporosis	Stroke	Diabetes
Migraines	Polio	Prostate	Prosthesis	Mumps	Rheumatoid	Pneumonia	Tuberculosis
Tumors	Implants	V.D.	Bleeding	Chronic Fatigue	Tonsillitis	HBP	Ulcers
Asthma	Other________						

Family (Circle all that apply to your FAMILY MEMBERS)

AIDS/HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthritis	Depression	Heart Disease
Breast Lump	Bronchitis	Bulimia	Cancer	Fibromyalgia	Chicken Pox	Gout	Measles
Emphysema	Epilepsy	Fractures	Glaucoma	Cataracts	Gonorrhea	Liver Disease	Parkinson's
Hepatitis	Hernia	Herniated Disc	Herpes	Goiter	Kidney Disease	Pacemaker	Thyroid
Headaches	Miscarriage	Mono	M.S.	High Chol	Osteoporosis	Stroke	Diabetes
Migraines	Polio	Prostate	Prosthesis	Mumps	Rheumatoid	Pneumonia	Tuberculosis
Tumors	Implants	V.D.	Bleeding	Chronic Fatigue	Tonsillitis	HBP	Ulcers
Asthma	Other________						

Dates of Last Exams: ____________________

List any types of surgeries which you have had and the dates in which they occurred: ____________________

____________________.

Please list all medications/vitamin, prescribed or over-the-counter, you are currently taking: ____________________

____________________.

(Women) Are you pregnant? ☐ Yes ☐ No   Taking birth control? ☐ Yes ☐ No

Daily Habits

What type of exercise do you perform on a daily basis? ☐ None ☐ Moderate ☐ Heavy

What do your daily work habits include? ____________________.

Do you smoke? ☐ Yes ☐ No   How much per day? ____________________.

How much alcohol do you consume weekly? __________ Caffeinated beverages? __________.

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child has a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Venti Chiropractic & Sports Health all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Ventimiglia or Dr. Tamburro may use my health care information and disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____

Please Print Name of Patient, Guardian, or Personal Representative Relationship to Patient

NOTICE OF PRIVACY PRACTICE

I have been offered and have read and understand the ***Notice of Privacy Practices*** and the ***Office Policies***

Signature: _____ Date: _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient to such care, it is essential for both to be working toward the same objective.

Chiropractic has only one goal. It is most important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum human potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we advise you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. NOR do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

_____ _____ _____

(Print Name) (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 Informed Consent 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 associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____.

_____ _____

(Signature) (Date)