OFFICE USE ONLY: _____**N** _____**CC** _____**ADMIN/INS** _____**SC**

Dr. Jack F. Sarro D.C. **198 Columbia Road, Hanover, MA 02339** **781-829-9300**

NAME:_____ Date:_____
Address:_____ City:_____ State:_____ Zip:_____
Date of Birth:_____ Age:_____ Spouses Name: _____
Home Phone:_____ Referred By:_____
Work Phone: _____ Occupation:_____ Employer:_____
Cell Phone:_____ Cell Phone Service Carrier:_____
Email:_____ Marital Status: Single Married Widowed Separated Divorced

MAIN COMPLAINT:

_____
Additional Complaints: _____
Pain began: when and how? _____
Circle your type of pain: **dull aching sharp radiating burning throbbing pinching locking stiffness tightness**
Does the pain travel or radiate anywhere? **Y N** Where? _____
Any numbness or tingling in your body? **Y N** Where? _____
Circle how painful on a 1-10 scale: **(No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint)**
How often do you have it?_____
How long does it last? _____
What makes your pain worse? _____
Is it interfering with your? (Please Circle) **Daily Routine Work Sleep Exercise Family Socializing Mood Recreation**
What makes your pain better? _____
PREVIOUS TREATMENT, HOMECARE, MEDICATIONS, or SURGERIES you have tried for this problem?:

_____
_____
Previous chiropractic treatment? **Y N** Previous Chiropractor: _____ Outcome? _____

ACCIDENT INFORMATION:
Is this condition due to an accident? **Y N** **Date of Accident:**_____
Circle type of accident: **Auto Work Home Other**_____
Have you reported your accident to? (Circle One) **Auto Insurance Employer Worker Comp**

_____
_____

PAST HEALTH HISTORY:
List all SURGERIES you have had & date: _____
Previous accidents, injuries, or TRAUMA:_____
Have you ever broken any BONES? Y N Which bones?_____
Circle major ILLNESSES you have or have had: Heart Disease Cancer Diabetes Blood Pressure Stroke Arthritis Lung Disease
Please list ANY additional HEALTH PROBLEMS:_____

_____

ALLERGIES: (Medication, Food, Seasonal etc.) _____

MEDICATIONS/ VITAMINS:	**Reason for taking:**	**MEDICATIONS/ VITAMINS:**	**Reason for taking:**
_____	_____	_____	_____
_____	_____	_____	_____

FEMALES:
# of children?_____ **What ages?** _____ Are you pregnant? **Y N** Date of last period?_____

FAMILY HEALTH HISTORY:
Common health problems of relatives: _____
Cause of death of immediate family members:

Relationship and Cause of Death	**Age at death**	**Relationship and Cause of Death**	**Age at death**
_____	_____	_____	_____
_____	_____	_____	_____

SOCIAL HEALTH HISTROY:
Education Level: (Circle one) **high school some college college graduate post graduate**
Job description & schedule: _____
Recreation/ Hobbies: _____ **Healthy Diet?**_____
Exercise_____per/WK **Tobacco** _____per/WK **Alcohol** _____per/WK **Drugs**_____per/WK

Patient or Parent Signature:_____ **Date:**_____

Doctor's Signature:_____ **Date:**_____

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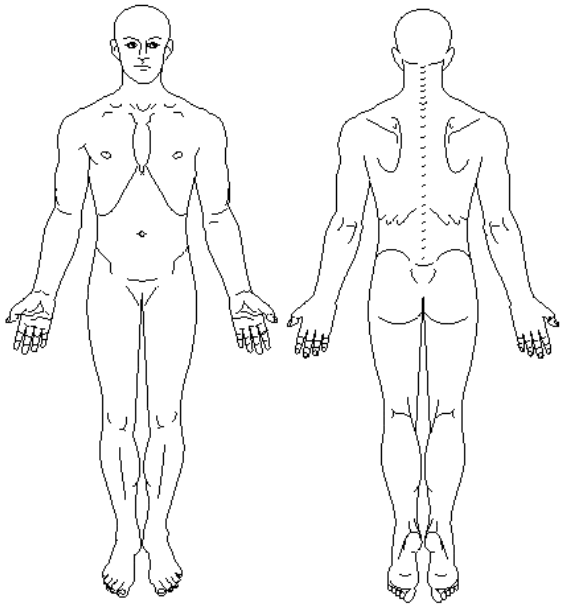
Name: _____ **Date:** _____
(Please Print)

1) Please use the key to the left to mark your pain on the diagram below.

S =	SHARP
D =	DULL
A =	ACHING
B =	BURNING
N =	NUMBNESS
T =	TINGLING
R =	RADIATING
P =	PINCHING



NO PAIN *** Please Circle Your Pain Level On the Scale Below: *** **WORST PAIN**

0 1 2 3 4 5 6 7 8 9 10

2) Please check off all symptoms below that you have now or have had in the past.

GENERAL	**LUNGS**	**DIGESTIVE**	**SKIN/ BREAST**
❑ SLEEP PROBLEMS	❑ COUGHING	❑ HEARTBURN	❑ RASHES
❑ FATIGUE	❑ SHORTNESS OF BREATH	❑ VOMITING	❑ MOLE PROBLEMS
❑ NO APPETITE	❑ WHEEZING/ ASTHMA	❑ NAUSEA	❑ SKIN CANCER
❑ WEIGHT LOSS	❑ SPITTING UP BLOOD	❑ BLOODY STOOLS	❑ DANDRUFF
❑ WEIGHT GAIN	❑ SLEEP APNEA	❑ IBS CRAMPS	❑ ECZEMA
❑ INFECTIONS	**HEART**	❑ COLITIS OR CHROHNS	❑ PSORIASIS
❑ EXCESS THIRST	❑ HI/ LOW BLOOD PRESSURE	❑ DIARRHEA	❑ BREAST LUMPS
❑ FEVER/ CHILLS	❑ CHEST PAIN	❑ CONSTIPATION	❑ BREAST PAIN
❑ ANEMIA	❑ PALPITATIONS	❑ RECTAL BLOOD	❑ BREAST DISCHARGE
❑ NIGHT SWEATS	❑ HEAVY IN CHEST	**URINARY**	**NERVOUS SYSTEM**
HEAD E/E/N/TH	❑ ANKLES SWELL	❑ EXCESSIVE URINATION	❑ STROKE
❑ SINUS PAIN	**MUSCLES/JOINTS**	❑ PAIN ON URINATION	❑ HEADACHES
❑ BLURRED VISION	❑ JOINTS SWOLLEN	❑ BLOOD IN URINE	❑ POOR BALANCE
❑ EYE PAIN	❑ JOINT PAIN	❑ BLADDER LEAKS	❑ DIZZINESS
❑ HEARING LOSS	❑ MUSCLE STIFFNESS	**REPRODUCTIVE**	❑ NUMBNESS OR TINGLING
❑ RINGING EARS	❑ MUSCLE ACHES	❑ PELVIC PAIN	❑ WEAKNESS
❑ SWALLOW PAIN	❑ NECK PAIN	❑ PAINFULL PERIODS	❑ BLACKOUTS
❑ CONGESTED NOSE	❑ BACK PAIN	❑ INFERTILITY	❑ SHAKING
❑ SORE THROATS	❑ PAIN WALKING	❑ IMPOTENCE	**PSYCHIATRIC**
IMMUNE SYSTEM	**ENDOCRINE**	**LYMPHATIC/ BLOOD**	❑ ANXIETY
❑ ALLERGIES	❑ DIABETES	❑ SWOLLEN GLANDS	❑ DEPRESSION
❑ CANCER	❑ THYROID PROBLEMS	❑ BLEED EASILY	❑ MENTAL ILLNESS
❑ AIDS/ HIV	❑ HOT FLASHES	❑ SLOW HEALER	❑ HALLUCINATIONS

Patient Signature: _____ **Date:** _____

Doctor Signature: _____ **Date:** _____

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Patient Name: _____

(Please Print)

1) Privacy/Confidentiality Notice:

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the ***Health Insurance Portability and Accountability*** **Act of 1996 (HIPPA)**, we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have read a copy of The *Notice of Privacy Practices for Protected Health Information* and will receive a copy upon request.

*** Signature:** _____ **Date:** _____

2) Insurance/Financial Agreement:

Patient Name or Parent responsible for this account: _____

Insurance Company: _____

Policy Identification # _____ Group # (If Applicable) _____

Insurance Assignment and Release of Information/ Direction to Pay Dr. Jack F. Sarro D.C. Directly

I, the undersigned certify that I (or my dependent) have **insurance coverage with**: **(write insurance company name on line below)**

_____

and assign directly to Dr. Jack F. Sarro D.C. 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 hereby authorize the doctor to release all necessary information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I hereby authorize and direct the above named insurance company to reimburse and pay all insurance benefits directly to Dr. Jack F. Sarro D.C. for services and treatment provided to me.

*** Signature:** _____ **Date:** _____

Relationship to Patient: _____

3) Patient Informed Consent to Treatment:

1) Dr. Sarro has reviewed with me my Health History, Exam and X-Ray Findings, Diagnosis, and Treatment Plan. I have had the opportunity to ask questions and address any concerns that I have.
2) Dr. Sarro has attempted to answer the following questions to the best of his ability: What is wrong with me? Can I be helped? How long may it take? How much will it cost?
3) Methods of treatment and how it relates to my condition have been explained to me.
4) I have been informed that nerve and disc involvement may be part of my condition. This may include inflammation, degeneration, bulging, herniation, rupture, and fragmentation.
5) Treatment options have been explained to me including the probable material benefits, risks, and outcomes of this chiropractic treatment, physical therapy, medication therapy, surgical intervention, and no intervention.
6) It has been explained that with or without treatment my condition may improve, not change, or get worse.
7) It has been further explained that I may experience soreness and pain following chiropractic treatment.
8) I understand that all patients are accepted on a trial basis. No guarantee of cure or results has been promised to me. Further testing or referral to another health provider may be recommended if necessary.
9) I understand that each patient's individual healing ability and response to treatment is different.
10) I understand that the results and outcome of my treatment will be greatly influenced by my following recommendations, my keeping appointments, and my active participation to take care of my health condition.

By signing below I agree to begin treatment in this office under the above listed terms.

*** Signature:** _____ **Date:** _____