**OFFICE USE ONLY: _____N _____CC _____ADMIN/INS _____SC ID#_____**

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

Patient Name:_____Date:_____

Address:_____City:_____State:_____Zip:_____

Date of Birth:_____Age:_____Spouses Name: _____

Home Phone:_____Referred By:_____

Work Phone: _____Occupation:_____Employer:_____

Cell Phone:_____Cell Phone Carrier:_____

Email:_____

Marital Status: Single Married Widowed Separated Divorced

**PAIN LOCATION:** Where is your pain?

_____

_____

Pain began: when and how? _____

Describe your pain: (Circle all) **dull aching sharp shooting radiating soreness stiffness tightness locking burning pinching throbbing numbness tingling**

Does your pain travel or radiate anywhere? **Y N** Where? _____

Any numbness or tingling in your body? **Y N** Where? _____

How painful on a 1-10 scale: **(mild) 0 1 2 3 4 5 6 7 8 9 10 (severe)**

How often do you have it?_____

How long does it last? _____

What makes your pain better? _____

What makes your pain worse? _____

Pain interferes with: (Circle all)

**daily routine work school sleep exercise sports family socializing mood recreation**

Previous treatment including self-care you tried for your pain?

_____

_____

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 all) **Auto Insurance Employer Worker Comp**

_____

_____

Patient Name:_____Date:_____

## PAST HEALTH HISTORY:

**Surgeries**: _____

**Accidents and injuries**:_____

**Broken Bones**:_____

**Illnesses**: (Circle all)

**Heart Disease** **Cancer** **Diabetes** **Blood Pressure** **Stroke** **Arthritis** **Lung Disease**

Other health problems:_____

**Allergies:**_____

**# of children?**_____ **What ages?** _____

Are you pregnant? **Y** **N** Date last period began?_____

**MEDICATIONS:** **Reason for taking:** **SUPPLEMENTS:** **Reason for taking:**

_____

_____

## 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 HISTORY:

Education Level: (Circle one) **high school** **some college** **college graduate** **post graduate**

Job description & schedule: _____

Recreation or Hobbies: _____Healthy Diet?_____

Do you exercise?_____

Do you smoke?_____

Do you drink alcohol?_____

Do you take recreational drugs?_____

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

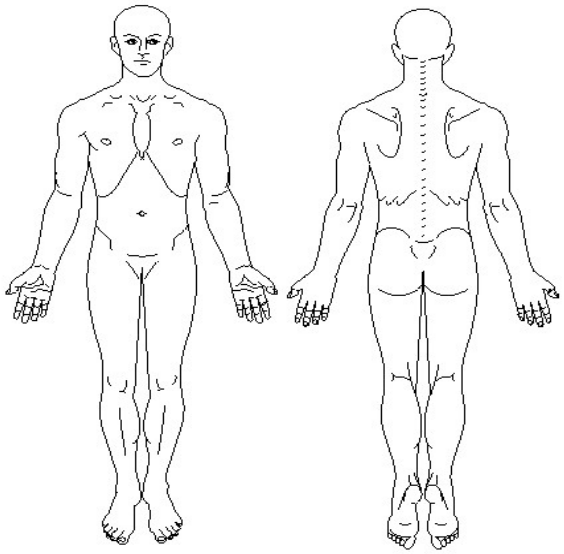
**Doctor's Signature:**_____**Date:**_____

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

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

## 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  **Circle your pain level on the scale below**  Severe Pain

0 1 2 3 4 5 6 7 8 9 10

## 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 and 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 | ❑ painful 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:** _____

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

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

## Privacy and 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:**_____

## Insurance and 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:

Name of Insurance Company _____
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 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:_____

## 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, I agree to begin treatment in this office under the above listed terms.

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