DR. ROSANNE BUTERA

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Date: ____/____/_____ File #: _____

ABOUT YOU

Patient Name: _____ _____ _____ ❑ Male ❑ Female
LAST FIRST MI

What you prefer to be called: _____ Birthdate: ____/____/_____ Age: _____ SS#:_____

Mailing Address: _____ _____ _____ _____
CITY STATE ZIP

Telephone Home: _____ Work: _____ Other: _____

E-mail Address: _____ Occupation: _____

Employer: _____ How long?: _____

Employer's Address: _____ _____ _____ _____
CITY STATE ZIP

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed Spouse's Name: _____

Do you have children? ☐ Yes ☐ No How Many? _____ Referred by: _____

YOUR HEALTH

Are you currently taking any medications?

❑ Nerve Pills ❑ Pain Killers (including aspirin) ❑ Muscle Relaxers
❑ Stimulants ❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Others _____

Do you have or have ever had one of the following diseases or conditions?

❑ Heart Attack/Stroke	❑ Congenital Heart Defect	❑ Alcohol/Drug Abuse	❑ HIV+/AIDS
❑ Frequent Neck Pain	❑ High/Low Blood Pressure	❑ Severe/Frequent Headaches	❑ Fainting/Seizures/Epilepsy
❑ Diabetes/Tuberculosis	❑ Lower Back Problems	❑ Heart Surg./Pacemaker	❑ Mitral Valve Prolapse
❑ Venereal Disease	❑ Shingles/Arthritis	❑ Emphysema	❑ Glaucoma
❑ Psychiatric Problems	❑ Kidney Problems	❑ Sinus Problems	❑ Artificial Bones/Joints
❑ Heart Murmur	❑ Artificial Valves	❑ Hepatitis	❑ Cancer/Chemotherapy
❑ Anemia	❑ Rheumatic Fever	❑ Ulcers/Colitis	❑ Asthma

Have you had chiropractic treatment in the past? ❑ Yes ❑ No **When?**_____ **How long?**_____

Are you: On a special diet? ❑ Yes ❑ No / Taking supplements or vitamins? ❑ Yes ❑ No

Do you: Exercise? ❑ Yes ❑ No / Smoke? ❑ Yes ❑ No How much?_____ How long? _____

How old is your mattress?_____ Is it comfortable? ❑ Yes ❑ No / Do you use ❑ Heel/Sole Lifts ❑ Inner Soles ❑ Arch Supports

Women: Are you taking Birth Control? ❑ Yes ❑ No / Pregnant? ❑ Yes ❑ No / Nursing? ❑ Yes ❑ No

Any other serious medical condition(s) you have or have had: _____

Previous surgeries with dates: _____

Past serious accidents with dates: _____

Please list any allergies: _____

Family health history: _____

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Reason For Visit

The reason for this visit is a result of (*Please circle*): Work/Sports/Auto Accident, Physical Trauma, Chronic Pain

*(Explain what happened)*_____

Describe your pain, including location:_____

When did condition begin? _____

Is this condition ❑ Getting worse ❑ Constant ❑Comes and goes

Does your condition interfere with ❑ Work ❑ Sleep ❑ Daily routine

(If so, please explain):_____

Have you had this or similar conditions in the past? ❑ Yes ❑ No

*(If so, please explain):*_____

Have you seen a Medical Physician for this condition? ❑ Yes ❑No

Physician Name: _____

Accident or Injury

Did accident render you unconscious? ❑ Yes ❑ No If yes, for how long? _____

How did you feel immediately afterwards? _____

Did you go to a Hospital or Doctor? ❑ Yes ❑ No ❑ Immediately (❑ Ambulance) ❑ The next day ❑ 2 or more days later

Name of Hospital or Doctor: _____ Doctor is a: ❑ D.C. ❑ M.D. ❑ D.O. ❑ D.D.S.

Describe any treatment you received: _____

Were X-rays taken? ❑ Yes ❑ No Was medication prescribed? ❑ Yes ❑ No

Have you been able to work since the injury? ❑ Yes ❑ No Are your work activities restricted due to the injury? ❑ Yes ❑ No

Check any symptoms which are a result of this accident:

❑ Dizziness	❑ Difficulty Sleeping	❑ Jaw Problems	❑ Nausea
❑ Memory Loss	❑ Irritability	❑ Arm/Shoulder Pain	❑ Back Pain
❑ Headache(s)	❑ Fatigue	❑ Numb Hands/Fingers	❑ Blurred Vision
❑ Tension	❑ Chest Pain	❑ Back Stiffness	❑ Buzzing in Ear
❑ Neck Pain	❑ Shortness of Breath	❑ Leg Pain	❑ Ears Ringing
❑ Neck Stiff	❑Stomach Upset	❑ Numb Feet/Toes	

Have you retained an attorney? ❑ Yes ❑ No

If yes, whom? _____

Attorney telephone number: _____

Indicate your degree of comfort while performing the following (C=Comfortable, U=Uncomfortable, even if only sometimes, P=Painful):

	C	U	P		C	U	P
Lying on back	❑	❑	❑	Running	❑	❑	❑
Lying on side	❑	❑	❑	Sports	❑	❑	❑
Lying on stomach	❑	❑	❑	Working	❑	❑	❑
Sitting	❑	❑	❑	Lifting	❑	❑	❑
Standing	❑	❑	❑	Bending	❑	❑	❑
Stretching	❑	❑	❑	Kneeling	❑	❑	❑
Lovemaking	❑	❑	❑	Pulling	❑	❑	❑
Walking	❑	❑	❑	Reaching	❑	❑	❑

AUTOMOBILE ACCIDENT

Date and Time of Accident: _____ at about _____ ❑a.m. ❑p.m.

Were you the ❑ Driver ❑ Front Passenger ❑ Rear Passenger

Number of people in accident vehicle: _____

Was anyone issued a traffic violation? ❑ Yes ❑ No To whom? _____

Location/street of the accident: _____

Make and model of the vehicle you were occupying: _____

In what direction were you traveling: ❑ North ❑ South ❑ East ❑ West

Approximate speed of your vehicle: _____

Did the accident involve another vehicle? ❑ Yes ❑ No

If No, please explain:

_____

_____

Make and model of the other vehicle: _____

Direction the other vehicle was traveling: ❑ North ❑ South ❑ East ❑ West Speed:_____

Please describe the accident:

_____

_____

Did the impact to your vehicle come from the: ❑ Front ❑ Rear ❑ Right Side ❑ Left Side ❑ Other

Were you facing: ❑ Right ❑ Left ❑ Forward Were you ❑ aware of or ❑ surprised by the impact?

Where was the headrest with respect to the base of your skull? ❑ Above ❑ Below ❑ At base of skull

Did any part of your body strike anything in the vehicle? ❑ Yes ❑ No

If yes, please explain: _____

Did the police come to the accident site? ❑ Yes ❑ No

Was a police report filed? ❑ Yes ❑ No

Were there any witnesses? ❑ Yes ❑ No

Were you wearing your seatbelt? ❑ Yes ❑ No

Was the vehicle equipped with airbags? ❑ Yes ❑ No

If yes, did they inflate? ❑ Yes ❑ No

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Insurance Info

Primary Insurance:

Insurance Company:_____

Address:_____

City:_____State: _____ Zip:_____

Telephone #:_____

Insured's SS#:_____

Group#:_____

Policy#:_____

Insured's Name:_____

Relation to Patient:_____

Date of Birth:_____

2nd Insurance Source or Auto Insurance:

Type of Insurance:_____

Insurance Company:_____

Address:_____

City:_____State: _____ Zip:_____

Telephone #:_____

Insured's SS#:_____

Group#:_____Policy#:_____

Insured's Name:_____

Date of Birth:_____

Insured's Employer:_____

Agent's Name:_____

Claim #:_____

Emergency Contact

Contact Name:_____ Relation:_____

Primary Phone #:_____ Second Phone #:_____

Your Medical Doctor:_____ Telephone #:_____

Account Info

Person ultimately responsible for account:

Name: _____ Relation: _____ Work Phone #:_____

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

SS#: _____ Driver's License #: _____

Payment method: ❑ Cash ❑Check ❑ Credit Card: Type:_____ _____ _____/_____

Number Exp. Date

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office). _____

Initials

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees and any other expenses incurred in collectiny your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

❑ Adult Patient ❑ Parent or Guardian ❑ Spouse Signature:_____ Date: _____

I am responsible for this account: Signature: _____ Date: _____