Advanced Alternative HealthCare
Nicholas Zuccala, DC, CCSP

Patient Name _____ **Date** _____

PATIENT INTAKE

IMPORTANT! Please complete all sections

If under the age of 18, Parent/Guardian Name _____

Address_____ City_____ State _____ Zip Code _____

Date of Birth _____/_____/_____ Sex: M F Marital Status: M S D W Spouse Name_____

Preferred Language _____Race _____ Ethnicity (circle): Hispanic/Latino Not Hispanic/Latino Decline to Answer

Social Security #_____-_____-_____ Email Address _____

Home Phone (_____) _____ Cell Phone (_____) _____ Preferred contact: Home Cell Text

Cell Carrier (for text reminders) AT&T Sprint/Nextel T-Mobile Verizon Other _____

Occupation_____ Employer/School_____

Employer Address_____Employer Phone_____

Primary Care Physician_____ Phone_____ May we contact your PCP regarding your care? Y N

Emergency Contact: Name_____ Relationship_____ Phone_____

Have you ever received Chiropractic Care? Yes No If yes, when? _____

Name of most recent Chiropractor: _____

How did you learn of this office?

___ Online Search (circle) Google Bing Yahoo Other _____

___ Referral; whom may we thank for referring you? _____

Reason for seeking chiropractic care: _____

Is condition related to an auto accident or job-related injury? Yes No

Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):

_____

_____

_____

Past Health History:

Previous Injury or Trauma _____

_____

Have you ever broken any bones? Which? _____

15 Bellemeade Ave, Suite 11
Smithtown, NY 11787

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Medications / Reason for taking

_____

_____

_____

Allergies (to Medication, Food, Environment)

_____

_____

Surgeries / Date

_____

_____

_____

Females: Pregnancies / Date of Delivery / Outcome

_____

_____

_____

Family Health History

Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Cardiac disease □ Neurological diseases
□ Adopted/Unknown □ Cardiac disease under age 40 □ Psychiatric disease □ Diabetes
□ Other _____ □ None of the above

Deaths in immediate family

Cause of parents death	Age at death	Cause of siblings death	Age at death

Social History

A. Height _____ **Weight** _____

B. Recreational activities / Hobbies _____

_____

C. Do you exercise? YES NO

Type/Frequency of exercise _____

_____

D. Smoking (circle one) Never Smoker Former Smoker
Current Every Day Smoker Current Some Day Smoker
_____ packs per week

E. Alcohol Use _____ drinks per week

F. Drug Use (whether past or present) – describe _____

_____

Patient or Guardian Signature _____ **Date**_____

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REVIEW OF SYSTEMS

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other_____ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ **Hypertension**
□ Heart disease/problems □ Pacemaker □ Angina/chest pain □ Irregular heartbeat
□ Other _____ □ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell
□ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ **Diabetes**
□ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ **Bowel or Bladder Incontinence (can't control)**
□ Bladder Infections □ Difficulty urinating □ Kidney disease □ Dialysis □ Other_____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other_____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other _____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other_____ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Osteoporosis □ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture
□ Spinal surgery □ Joint surgery □ Arthritis (unknown type) □ Scoliosis □ Metal implants
□ **Upper or Lower Extremity Weakness** □ Other _____ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations
□ Schizophrenia □ Psychiatric hospitalizations □ Other _____ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here? _____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge. I hereby authorize this office of Chiropractic to provide me with chiropractic care in accordance with this state's statutes. If my insurance will be billed, I authorize the release of any medical or other information necessary to process my claims, and I authorize the use of my signature on all insurance submissions. I request payment of healthcare benefits to Nicholas Zuccala, DC, CCSP, for services performed. I understand that I am financially responsible for all charges, whether or not paid by insurance.

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SYMPTOMS

Symptom _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin **suddenly** or **gradually**? (circle one)
  - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, Other (please describe): _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, standing, sitting, lying down, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

A = ACHE

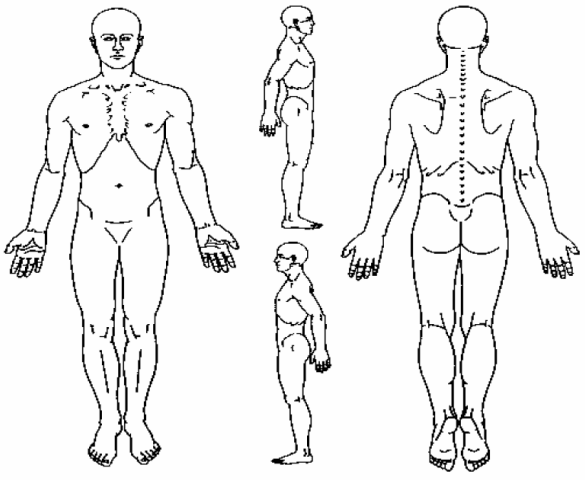
B = BURNING

N = NUMBNESS

P = PINS & NEEDLES

S = STABBING

O = OTHER_____



On the diagram to the left, please indicate where, and what type of symptoms that you are experiencing, right now. Write the appropriate abbreviations (see key) over the area of the body where those symptoms are occurring.

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Dr.'s Notes: _____

_____

_____

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