

Confidential Patient Care History

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Dear Patient: The information contained within this form is considered confidential. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond, we will not accept your case. Please be as neat and as accurate as possible when completing this form. Thank you. -- Dr. Santoro

Personal History

Name:		Date:
Address:		
City:	State:	Zip:
Home #:	Work #:	Email:
Date of Birth:	Age:	Sex (circle one): M F
Marital Status:	Name of Spouse (if applicable):	
No. of Children:	Referred By:	

Medical Condition

1. Describe Current Health Condition:
2. Explain Major Complaint:
3. List Other Doctors Seen for this Condition:
4. List Types of Treatment Administered:
5. Explain Results:
6. Approximate Date Condition Began?
7. Has Condition Occurred Before, and if so, when?
8. Is this Condition Related to (please check one) <input type="checkbox"/> Auto Accident <input type="checkbox"/> Job <input type="checkbox"/> Fall <input type="checkbox"/> Other (if other, please explain)?
9. Explain How this Condition Interferes with Your Life:
10. What Goals do You Hope to Achieve through Treatment or Corrective Care?
11. What Activities and/or Circumstances Aggravate Your Condition?
12. Condition is (check one) <input type="checkbox"/> Worsening <input type="checkbox"/> Constant <input type="checkbox"/> Fluctuating.
13. Approximate Date of Last Chiropractic Visit?

14. List All Conditions for Which You are Currently Being Treated.

15. List All Medications You are Currently Taking, Including Prescription and Over-the-counter Drugs and Herbal Remedies.

16. If Female, are You Pregnant?

Medical History

1. List All Major Surgeries/Operations and the Dates Performed.

2. List All Major Accidents/Falls.

3. List Hospitalizations (other than above).

4. Date of Last Physical Exam?

Performed by Whom?

5. Check All Conditions that Apply to You:

Cancer

Allergies

Arthritis

Headaches

Neck Pain

Stomach

Other

If Other, Please Explain:

Insurance Information

Name of Primary Coverage:

Policy #

Name of Supplemental Coverage:

Policy #

If Auto Injury, List Company Name:

Claim #

Claim Representative's Name:

Phone #

If Work Related, List Employer's Name:

Phone #

Was an Accident Report Filed?

(If Yes, Please Provide Office with a Copy)

Patient Authorization

I understand and agree that health insurance and accident policies are an arrangement between my insurance company and me.

I hereby authorize the doctor to treat my condition as he deems appropriate through the use of manipulation throughout my spine. The doctor will not be held responsible for any pre-existing, medically-diagnosed conditions, nor for any medical diagnosis.

Patient's Signature: _____

Date: _____

Guardian's/Spouse's _____

Date: _____

Signature Authorizing Care If Other Than Patient