ISLE OF WELLNESS

New Patient Exam with Dr. Marina Mangano

Name _____ Date _____

Address_____ City _____ State _____ Zip Code _____

Primary Phone _____ Email_____

Emergency Contact Name _____ Emergency Contact Phone # _____

Date of Birth_____ Age_____ How did you find us?_____

Occupation_____ Employer_____

1. **Reasons for seeking chiropractic care:**
   Primary Reason: _____
   Secondary Reason: _____

2. **Previous interventions, treatments, medications, surgery, or care you've sought for primary complaint:**
   _____
   _____

3. **Past Health History:**
   a. **Previous illnesses you've had in your life:**
      _____
      _____
   b. **Previous Injury or Trauma (including any broken bones or sprains):**
      _____
      _____
   c. **Surgeries (surgical or cosmetic) Date and Type of Surgery:**
      _____
      _____
   d. **Do you have any scars? (Surgical or Non-Surgical) If so, where?**
      _____
   e. **Allergies:**
      _____
   f. **Medications and Reasons for Taking:**
      _____
      _____
   g. **Pregnancies (date of delivery) and Outcomes:**

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4. **Family Health History:**

   Associated health problems of relatives:
   _____
   _____

   Cause of parent's or sibling's death (Age at death)_____

5. **Social and Occupational History:**
   Employer, Job Description, Schedule:_____
   Exercise/Recreational activities, intensity, frequency:_____
   _____
   Alcohol and/or drug use:_____

6. **Diet and other Information:**
   How much water do you drink per day? _____ How many hours per night do you sleep? _____
   Dietary Restrictions? _____
   Do you clench/grind your teeth? _____ If so, do you wear a dental splint? _____
   Do you suffer from headaches? (Where/how often?)_____
   Rate Sleep Quality 0-10_____? Do you snore? _____Do you wake up feeling refreshed? _____
   Do you suffer from stress incontinence? (urinating with sneezing, jumping, running, etc? _____

Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have**

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE
○	○	Osteoporosis	○	○	Arthritis	○	○	Scoliosis	○	○	Neck pain	○	○	Back problems	○	○	Hip disorders	○
○	○	Knee injuries	○	○	Foot/ankle pain	○	○	Shoulder problems	○	○	Elbow/wrist pain	○	○	TMJ issues	○	○	Poor posture	

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE
○	○	Anxiety	○	○	Depression	○	○	Headache	○	○	Dizziness	○	○	Pins and needles	○	○	Numbness	○

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE
○	○	High blood pressure	○	○	Low blood pressure	○	○	High cholesterol	○	○	Poor circulation	○	○	Angina	○	○	Excessive bruising	○

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE
○	○	Asthma	○	○	Apnea	○	○	Emphysema	○	○	Hay fever	○	○	Shortness of breath	○	○	Pneumonia	○

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE
○	○	Anorexia/bulimia	○	○	Ulcer	○	○	Food sensitivities	○	○	Heartburn	○	○	Constipation	○	○	Diarrhea	○

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE
○	○	Blurred vision	○	○	Ringing in ears	○	○	Hearing loss	○	○	Chronic ear infection	○	○	Loss of smell	○	○	Loss of taste	○

g. Integumentary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE
○	○	Skin cancer	○	○	Psoriasis	○	○	Eczema	○	○	Acne	○	○	Hair loss	○	○	Rash	○

Please list any additional symptoms that you would like the doctor to know about:
_____
_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient or Guardian Signature _____Date_____

DETAILED SUBJECTIVES

Please answer ALL #s for each symptom. Draw scars or painful areas on diagram.

[SYMPTOM #1]

1. The symptom(s) that have prompted me to seek care today include: _____

_____

2. And are the result of (darken circle): ◯ An accident or injury
◯ Work ◯ Auto ◯ Other _____
◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other _____

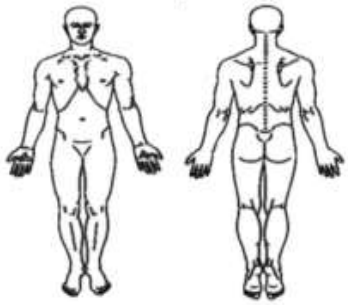
3. Onset (When did you first notice your current symptoms?)
_____

4. Intensity (How extreme are your current symptoms?)
0 ○○○○○○○○○○ 10
Absent Uncomfortable Agonizing

5. Duration and Timing (what % of the time do you feel it?)
◯ Constant ◯ Comes and goes. How Often? _____
_____

6. Quality of symptoms (What does it feel like?)
◯ Numbness
◯ Tingling
◯ Stiffness
◯ Dull
◯ Aching
◯ Cramps
◯ Nagging
◯ Sharp
◯ Burning
◯ Shooting
◯ Throbbing
◯ Stabbing
◯ Other _____

7. Location (Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)
_____

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)
What tends to worsen the problem? _____
What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptoms?)
◯ Prescription medication ◯ Surgery ◯ Ice
◯ Over-the-counter drugs ◯ Acupuncture ◯ Heat
◯ Homeopathic remedies ◯ Chiropractic Other _____
◯ Physical therapy ◯ Massage _____

[SYMPTOM #2 (if applicable)]

1. The symptom(s) that have prompted me to seek care today include: _____

_____

2. And are the result of (darken circle): ◯ An accident or injury
◯ Work ◯ Auto ◯ Other _____
◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other _____

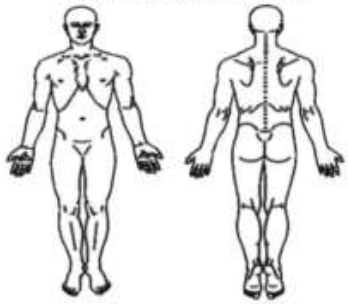
3. Onset (When did you first notice your current symptoms?)
_____

4. Intensity (How extreme are your current symptoms?)
0 ○○○○○○○○○○ 10
Absent Uncomfortable Agonizing

5. Duration and Timing (what % of the time do you feel it?)
◯ Constant ◯ Comes and goes. How Often? _____
_____

6. Quality of symptoms (What does it feel like?)
◯ Numbness
◯ Tingling
◯ Stiffness
◯ Dull
◯ Aching
◯ Cramps
◯ Nagging
◯ Sharp
◯ Burning
◯ Shooting
◯ Throbbing
◯ Stabbing
◯ Other _____

7. Location (Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)
_____

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)
What tends to worsen the problem? _____
What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptoms?)
◯ Prescription medication ◯ Surgery ◯ Ice
◯ Over-the-counter drugs ◯ Acupuncture ◯ Heat
◯ Homeopathic remedies ◯ Chiropractic Other _____
◯ Physical therapy ◯ Massage _____

INFORMED CONSENT- CHIROPRACTIC

By signing below, you agree to the following:

Within the practice of chiropractic and other manual therapies there are some risks during examination and treatment procedures including, but not limited to, temporary soreness, bruising, fractures, disc injuries, dislocations, sprains and increased symptom or pain, or no improvement of symptoms or pain. *A rare but serious risk associated with neck manipulation is stroke.*

The Doctor of Chiropractic or office staff is not able to anticipate all the risks and complications of care but relies on clinical judgment based on all of the facts known at the time of the procedure to make decisions that are in the best interest of the patient. There are no guaranties or assurances concerning the intended results of the treatment.

As an involved patient, you have the right to be informed about your condition and the recommended chiropractic procedures to be used, so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. Together, we will create a comfortable and safe practice that matches your preferences.

I consent to providing Dr. Marina Mangano with an updated and honest medical history. I recognize that care will include close contact and that this consent covers the entire course of treatment.

___ I consent to this treatment. ___ I do not consent to this treatment

Name:_____ Signature:_____ Date: _____

For a **minor or person represented by another party,** please sign on their behalf and state relationship.

Name:_____ Signature:_____ Date: _____

Relationship: _____

PAYMENT POLICY

Dr. Mangano Self-Pay Prices

Initial Office Examination (60 min)	$110.00
Follow-Up Treatments (20 min)	$65.00
Mobile Chiropractic (30 min)	$100.00
Private Yoga Sessions (60 min)	$85.00
Mobile Yoga Sessions (60 min)	$100.00

SELF-PAY POLICY

As a self-pay patient, I understand Dr Mangano will NOT be filing/submitting/billing any treatments to my medical health insurance because she is not contracted with any health insurance at this time. And further, I understand Dr. Mangano is NOT responsible for any claims I choose to file/submit/bill to health insurance on my own.

CANCELLATION POLICY

The treatment plan prescribed by Dr. Mangano is vital to resolving your injury as quickly as possible, so patients are strongly encouraged to follow the doctor's guidelines regarding at-home exercises and future office appointments. In an effort to give best quality care, the doctor spends 60 minutes with the patient for the initial exam and 20 minutes with the patient for follow-up visits. Out of courtesy to the doctor, staff, and other patients, **please only make appointments that you are able to keep**. Dr. Mangano has a 24-hour cancellation policy.

Cancellation Policy: We require 24 hours to cancel or reschedule an appointment; otherwise a $50 cancelation fee or a $65 no-show fee will be applied to your account.

I understand that by signing below I accept the financial arrangements. Payment is due at time that services are rendered unless financial arrangements have been made with the doctor. If the patient is a minor, a parent must either be present at each appointment or provide the patient with funds to pay at the time services are rendered.

Please sign that you understand and agree to the above policies.

_____ _____

Patient's Name (signature) Date

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conduction of other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, legal proceedings, and law enforcement. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____
Signature of Patient or Representative Date

_____
Printed Name