La Ruffa Chiropractic + Sports Rehab
Integration. Innovation. Invigoration.

NEW PATIENT INFORMATION

Patient Name	Preferred Name		Date of Birth
Street Address	**City**	**State**	**Zip**
Home Phone	**Cell Phone**		**Work Phone**
Email Address	**Cell Phone Carrier/Provider (for text appointment reminders)**		
Emergency Contact Name	**Relationship**		**Phone**

Gender: □M □F Marital Status: □S □M □D □W Spouse's Name: _____

Who referred you to our office: _____

May we send your Primary Care Physician (PCP) a report of your visit? □ Yes □ No
If yes, to whom? PCP name: _____ PCP phone: _____

Were you injured in an auto accident? □ Yes □ No Date: _____
Were you injured in a work accident? □ Yes □ No Date: _____

Attorney's name (if applicable): _____

AUTHORIZATION AND ASSIGNMENT OF INSURANCE BENEFITS

I authorize the staff of Dr. La Ruffa to perform all necessary services needed during diagnosis and treatment.
I authorize the release of any medical information necessary to process and pay this claim. I authorize payment of health benefits, "Medical Reimbursement, and/or "Government Benefits" otherwise payable to me be paid directly to:

SPORTS & SPINE INJURY CENTER
AUGUST J LARUFFA III, DC
JOHN S SCOTT, PT

I understand that I am financially responsible for all charges whether or not paid by insurance.

_____
Patient/Guarantor's Signature Date

Office Financial Policy: (full policy posted in waiting room)
All payments including deductibles, co-payments, co-insurances, or other payments are expected at the time of service or by an authorized payment plan. If your insurance company has not paid a claim within 90 days of submission, you accept responsibility for payments in full for any outstanding balance. Initial: _____

Notice of Privacy Practice: (full notice posted in waiting room & available at front desk)
Complete information about how this office may use protected health information has been made available to me. I attest that I have had the opportunity to review and understand this privacy information. Initial: _____

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MEDICAL HISTORY

Please indicate if you have had any of the following medical conditions. (Circle all that apply)

Allergies	Fractures	Pacemaker
Anemia	Heart Disease	Parkinson's Disease
Appendicitis	Hernia	Pinched Nerve
Arthritis	Herniated Disk	Prosthesis
Cancer	High Blood Pressure	Rheumatoid Arthritis
Chemical Dependency	Migraines/Headaches	Scoliosis
Diabetes	Multiple Sclerosis	Stroke
Epilepsy	Osteoporosis	Thyroid Problems

Previous cortisone or other steroid injections: (location, date)_____ ☐ N/A

Previous surgeries: (type, date) _____ ☐ N/A

Current medications/supplements: _____

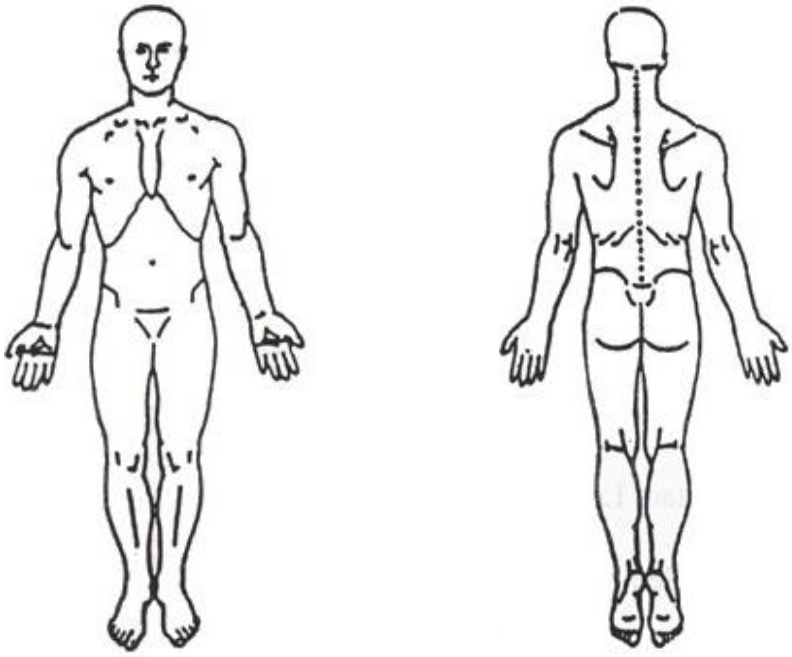
For women: are you pregnant? ☐ Yes ☐ No Date of last menstrual cycle: _____

FOR MEDICAL STAFF USE ONLY:

HEIGHT: _____ **WEIGHT:** _____ **BP:** _____ **PULSE:** _____

CURRENT COMPLAINT AREAS

Please mark on the figure below your areas of concern. You will be asked to provide a description of your condition(s) on the following page.



CURRENT COMPLAINT DETAILS

Starting with the most severe, please provide information for your current complaints.
(Please see the front desk if you have more than 2 complaint areas).

• Complaint 1.

Problem area: _____ **Onset date:** _____ **Onset reason**: _____

When present, how intense is the pain/condition: (none) 0 1 2 3 4 5 6 7 8 9 10 (excruciating)

How often is pain/condition present: 0-25% 25-50% 50-75% 75-100%

What relieves pain (check all that apply)

☐ laying ☐ standing ☐ chiropractic ☐ ice ☐ massage other: _____
☐ sitting ☐ stretching ☐ medication ☐ heat ☐ nothing _____

What aggravates pain (check all that apply)

☐ sitting ☐ computer ☐ range of motion ☐ daily living activities other: _____
☐ standing ☐ weight bearing ☐ reaching ☐ lifting/carrying objects _____
☐ sit-to-stand ☐ stand-to-sit ☐ sit-to-laying ☐ laying-to-sit

Quality of pain (check all that apply)

☐ aching ☐ shooting ☐ throbbing ☐ burning ☐ dull ☐ restriction/tension
☐ sharp ☐ tingling ☐ numbness ☐ spasm ☐ deep ☐ superficial

Current/previous treatments for this condition (check all that apply)

☐ chiropractic ☐ physical therapy ☐ medication: _____
☐ acupuncture ☐ injections ☐ other: _____

List any recreational or daily living activities you avoid due to pain: _____

• Complaint 2.

Problem area: _____ **Onset date:** _____ **Onset reason**: _____

When present, how intense is the pain/condition: (none) 0 1 2 3 4 5 6 7 8 9 10 (excruciating)

How often is pain/condition present: 0-25% 25-50% 50-75% 75-100%

What relieves pain (check all that apply)

☐ laying ☐ standing ☐ chiropractic ☐ ice ☐ massage other: _____
☐ sitting ☐ stretching ☐ medication ☐ heat ☐ nothing _____

What aggravates pain (check all that apply)

☐ sitting ☐ computer ☐ range of motion ☐ daily living activities other: _____
☐ standing ☐ weight bearing ☐ reaching ☐ lifting/carrying objects _____
☐ sit-to-stand ☐ stand-to-sit ☐ sit-to-laying ☐ laying-to-sit

Quality of pain (check all that apply)

☐ aching ☐ shooting ☐ throbbing ☐ burning ☐ dull ☐ restriction/tension
☐ sharp ☐ tingling ☐ numbness ☐ spasm ☐ deep ☐ superficial

Current/previous treatments for this condition (check all that apply)

☐ chiropractic ☐ physical therapy ☐ medication: _____
☐ acupuncture ☐ injections ☐ other: _____

List any recreational or daily living activities you avoid due to pain: _____

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CHIROPRACTIC INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me (or on the patient for whom I am legally responsible) by the doctor of chiropractic named below and/or other support staff who now or in the future treat me while working with the chiropractor named below, whether signatories to this form or not.

I have had the opportunity to discuss with the chiropractor and/or with other clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand that, like all health modalities, results are not guaranteed, and there is no promise of cure. I further understand that, as in the practice of medicine, the practice of chiropractic includes possible risks including fractures, disc injuries, strokes, dislocations, or sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment to perform procedures which the doctor feels are in my best interests (based upon the facts then known).

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include: over-the-counter analgesics and rest; prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand that I have the right to a second opinion if I have concerns about the nature of my symptoms and treatment options.

I have read the above consent and have had the opportunity to ask questions about its content, and by signing below I agree to chiropractic procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Dr. August La Ruffa III, DC

_____

Patient/Guardian Signature Date

ACUPUNCTURE INFORMED CONSENT

I hereby request and consent to the performance of acupuncture and other procedures within the scope of acupuncture on me (or on the patient for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while working with the acupuncturist named below, whether signatories to this form or not.

I understand that methods of treatment may include acupuncture, electrical stimulation, Chinese massage, Chinese herbal medicine, and nutritional counseling. I will immediately notify a member of the clinical staff if any unanticipated or unpleasant effects associated with treatment occur. I understand that results are not guaranteed.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects. Possible side effects include bruising, numbness or tingling near the needling sites, dizziness or fainting, and burns from the use of heat lamps. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture including lung puncture. Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements that have been recommended are traditionally considered safe, although some may be toxic in large doses. Some possible side effects of taking herbs are nausea, gas, vomiting, headache, diarrhea, and rashes. I understand that some herbs may be inappropriate during pregnancy and I will notify a clinical staff member if I am or become pregnant. I do not expect the clinical staff to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment to perform treatment that is in my best interest (based on facts known at the time).

I have read the above consent, have been made aware of the risks and benefits of acupuncture, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Dr. August La Ruffa III, DC

_____

Patient/Guardian Signature **Date**