Lombardi Chiropractic and Rehabilitation

Dr. Joseph P. Lombardi , D.C.
1430 West 38th Street Erie, PA 16508

Date ________________________ Social Security # _______________________

Name ____ Birthdate: _____________________

Address _______________________________ City __________ St. _____ Zip ____________

Home Phone ________________ Cell Phone ___________________________

Age ____ Sex ________ Height ________ Weight ________

Employer _________________________________ Type: __________________________

Family Physician____

<u>Insurance Information:</u> ____ Self _____ Spouse _____ Work Comp _____ Auto

Type: ______________ Insured's Name: ________________________

Insured's Date of Birth: ___________ Insured's SSN: __________________

<u>Condition</u>

Chief Complaint

1. ____

2. ____

3. ____

What Caused Problem?____

Problem Began ________________________ If Auto-Date of Accident ____________________

Other Doctors Seen for Problem : ____

Have you had this condition in the past? ____________________

If disabled from work list dates: ____

List All Present Medications: ____

<u>Past History</u>

Anyone in Family with Same Condition __________

Major Surgery: ____

Major Accidents or Falls: ____

Hospitalization: ____

Allergies: ____

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I give Lombardi Chiropractic and Rehabilitation permission to bill my insurance and to accept assignment of my insurance payment. I also understand that all deductibles and copays are my responsibility and due at the time of service.

Should an insurance company not cover certain services and deny covered services if they deem them “not medically necessary”, I will be responsible for those charges my insurance company denies.

____

Signature

____

Date

Lombardi Chiropractic and Rehabilitation

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Authorization To Release Medical Records

Date: __________

To: ____

You are hereby authorized and requested to furnish to Lombardi Chiropractic & Rehabilitation any/all medical records including but not limited to intake/discharge sheets, consult reports, history and physical, progress notes and diagnostic studies in your possession concerning the undersigned patient.

____
Signature

____________________________ ____________________________
Signature of Parent or Guardian Signature of Parent or Guardian

____
Parent Name

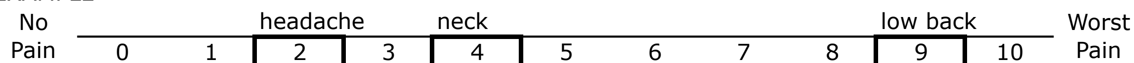
____
Patient Date of Birth

QUADRUPLE VISUAL ANALOGUE SCALE

INSTRUCTIONS: Please circle the number that best describes the question being asked.
NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum/maximum using the last 3 months as your reference. If you have completed this form before, indicate your average pain level since the last time you completed this form.

EXAMPLE

No Pain

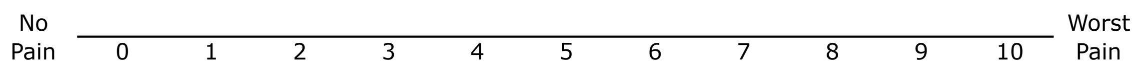


Worst Pain

##

1. What is your pain RIGHT NOW?

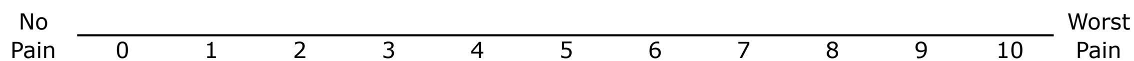
No Pain



Worst Pain

2. What is your TYPICAL or AVERAGE pain?

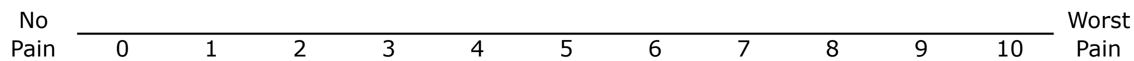
No Pain



Worst Pain

3. What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No Pain

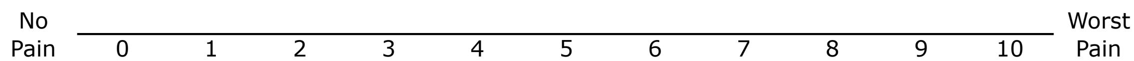


Worst Pain

What percentage of your awake hours is your pain at its best? _______ %

4. What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No Pain



Worst Pain

What percentage of your awake hours is your pain at its worst? _______ %

Name ______________________________ Age _______ Date ____________ Score _______

Score: #1 _______ %
#2 _______ %
#3 _______ %
Avg: _______ %

(Low Intensity = <50; High Intensity = >50)

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis and treatment plan.

Name: ______________________________

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- □ Appendicitis
- □ Scarlet fever
- □ Diphtheria
- □ Typhoid Fever
- □ Pneumonia
- □ Rheumatic Fever
- □ Polio
- □ Malaria
- □ Tuberculosis
- □ Whooping Cough
- □ Anemia
- □ Measles
- □ Mumps
- □ Small Pox
- □ Chicken Pox
- □ Diabetes
- □ Cancer
- □ Heart Disease
- □ Goiter
- □ Influenza
- □ Pleurisy
- □ Alcoholism
- □ Venereal Infection
- □ Arthritis
- □ Epilepsy
- □ Mental Disorder
- □ Lumbago
- □ Eczema
- □ AIDS

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST 6 MONTHS:

Musculo-Skeletal Code

- □ Low Back Pain
- □ Pain between Shoulders
- □ Neck Pain
- □ Arm Pain
- □ Joint Pain/Stiffness
- □ Walking Problems
- □ Difficult Chewing/ Clicking Jaw

Nervous System Code

- □ Numbness
- □ Paralysis
- □ Dizziness
- □ Forgetfulness
- □ Confusion/Depression
- □ Fainting
- □ Convulsions
- □ Cold/Tingling Extremities

General Code

- □ Allergies
- □ Loss of Sleep
- □ Fever

Gastro-Intestinal Code

- □ Poor/Excessive Appetite
- □ Excessive Thirst
- □ Frequent Nausea
- □ Vomiting
- □ Diarrhea
- □ Constipation
- □ Hemorrhoids
- □ Liver Trouble
- □ Gall Bladder Problems
- □ Weight Trouble
- □ Abdominal Cramps
- □ Gas/Bloating after Meals
- □ Heartburn
- □ Black/Bloody Stool
- □ Colitis

Genito-Urinary Code

- □ Bladder Trouble
- □ Painful/Excessive Urination
- □ Discolored Urine

C-V-R Code

- □ Chest Pain
- □ Short Breath
- □ Blood Pressure Problems
- □ Irregular Heartbeat
- □ Heart Problems
- □ Lung Problems/ Congestion
- □ Varicose Veins
- □ Ankle Swelling

EENT Code

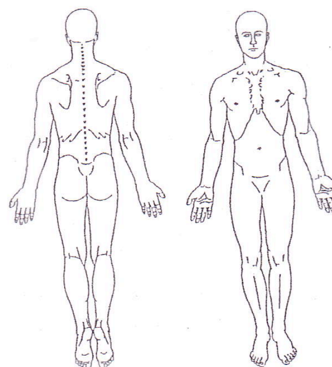
- □ Vision Problems
- □ Dental Problems
- □ Sore Throat
- □ Ear Aches
- □ Hearing Difficulty
- □ Stuffed Nose

Male/Female Code

- □ Menstrual Irregularity
- □ Menstrual Cramping
- □ Vagina Pain/Infections
- □ Breast Pain/Lumps
- □ Prostate/Sexual Dysfunction
- □ Genital Herpes

□ Are you pregnant □ Yes □ No □ Not Sure

Mark Area of Pain on Diagram Below



Family History

Mother	□ Diabetes	□ Heart	□ Kidney	□ Cancer	□ Back
Father	□ Diabetes	□ Heart	□ Kidney	□ Cancer	□ Back
Brother	□ Diabetes	□ Heart	□ Kidney	□ Cancer	□ Back
Sister	□ Diabetes	□ Heart	□ Kidney	□ Cancer	□ Back

Social History

□ Smoking ________Packs/Day
□ Drinking Alcohol ________ Occas ________Daily
□ Coffee ________Cups/Day
□ Exercise ______None ______Moderate ______Daily
Type: ______________________________
____
____

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES FOR LOMBARDI CHIROPRACTIC & REHABILITAION

I acknowledge that I am aware of the Privacy Acts and received Lombardi Chiropractic and Rehabilitation Notice of Privacy Practices regarding protected health information.

Date ______________________ Name of Patient __________________________________

____

Signature of Patient / Personal Representative