# Caputo Chiropractic Center

2020 Lawrenceville-Suwanee Rd. STE 101
Suwanee, GA 30024
770-962-0559

The following information is needed in order to better serve you. Please complete all questions. If you need help, please ask the receptionist. PLEASE PRINT

EMAIL: ___________________________________________ TODAY'S DATE: ________________

NAME: ___________________________________________ HOME/CELL PHONE: _________________

ADDRESS: _________________________ CITY: ______________ STATE: ______ ZIP CODE:__________

AGE: ____ BIRTHDATE: _________ SEX: ______ MARITIAL STATUS: S M W D NO. OF CHILDREN: _____

PLEASE CIRCLE ONE PAYMENT TYPE: CASH CHECK MASTER CARD/VISA AMERICAN EXPRESS

YOUR EMPLOYER: _________________________ OCCUPATION: _________________ YEARS ON JOB:____

EMPLOYER ADDRESS: __________________________ CITY:__________ STATE: _____ ZIP CODE:_______

OFFICE PHONE: ______________________ YOUR SS #: __________________ DRIV LIC. #:____________

DO YOU HAVE HEALTH INSURANCE WHERE YOU WORK? YES______ NO______

INSURANCE COMPANY:________________________________________PLAN/GROUP #:___________

NAME OF SPOUSE OR PARENT: _______________________________
BIRTHDATE:_______________

SPOUSE EMPLOYED BY: _____________________ OCCUPATION:___________ YEARS ON JOB: _______

EMPLOYER ADDRESS: _____________________ CITY: ____________ STATE: ______ ZIP CODE: _________

OFFICE PHONE: __________________ SPOUSE SS#: __________________ DRIV LIC: _____________

DOES YOUR SPOUSE HAVE HEALTH INSURANCE AT WORK? YES ____ NO ____ PLAN/ GROUP #: _______

DESCRIBE THE MAJOR COMPLAINTS THAT BRING YOU TO OUR OFFICE: ___________________________

________________________________________________________________________________
________

IS YOUR CONDITION DUE TO AN ACCIDENT? YES: _____ NO: _____ DATE OF ACCIDENT: ___________

TYPE OF ACCIDENT: AUTO:_______ WORK/ON JOB: _______ AT HOME:__________ OTHER: _______

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HAVE YOU EVER BEEN IN AN AUTO ACCIDENT? PAST YEAR:__PAST 5 YEARS: __OVER 5 YEARS:__NEVER_

I (WE) AGREE TO PAY FOR SERVICES RENDERED TO THE ABOVE MENTIONED PATIENT AS THE CHARGE IS INCURRED. I UNDERSTAND AND AGREE THAT HEALTH & ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MY SELF AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT OF ANY AND ALL SERVICES COVERED OR NON COVERED. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMEN, ANY FEES FOR PROFESSIONAL SERVICES RENDERED ME WILL BE IMMEDIATELY DUE AND PAYABLE.

PATIENT'S SIGNATURE________________________________________
DATE:__________________

SPOUSE OR GUARDIAN'S SIGNATURE __________________________ DATE: ___________________

**NOTICE TO OUR NEW PATIENTS**: FULL PAYMENT FOR SERVICE RENDERED IS DUE AT THE END OF EACH VISIT. IF FOR ANY REASON THIS REQUEST CANNOT BE MET, ARRANGEMENTS MUST BE MADE IN ADVANCE BEFORE SEEING THE DOCTOR.
**INSURANCE CASES**: ON ALL INSURANCE THE DEDUCTABLE MUST BE MET IN THE BEGINNING UNLESS PRICE ARRANGEMENTS ARE MADE.

HEALTH HISTORY

**PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST:**

| | | | |
|---|---|---|---|
| A.D.H.D<br>AIDS/HIV<br>ALCOHOLISM<br>ALLERGIES<br>ANEMIA<br>APPENDICITIS<br>ARTHRITIS<br>ASTHMA<br>BACK PAIN<br>BED-WETTING<br>BLEEDING<br>DISORDERS<br>BREAST<br>CONDITIONS<br>BREATHING<br>PROBLEMS<br>SINUS<br>BRONCHITIS<br>CANCER<br>CATARACTS<br>CHEMICAL<br>DEPENDENCY<br>CHEST PAIN<br>CHICKEN POX<br>COLD HANDS/FEET<br>COLD SWEATS/<br>FEVER<br>COLIC<br>COLON PROBLEMS<br>CONCUSSION | CONSTIPATION<br>DIARRHEA<br>DEPRESSION<br>DIABETES<br>DIGESTIVE<br>PROBLEMS<br>DIZZINESS<br>EAR<br>FLUID/INFECTION<br>EARS<br>RING/BUZZING<br>EATING<br>DISORDERS<br>EMPHYSEMA<br>EPILEPSY<br>FACE FLUSHED<br>FAINTING<br>FRACTURES<br>GLAUCOMA<br>GOITER<br>GONORRHEA<br>GOUT<br>GROWING PAINS<br>HEAVY HEAD<br>HEADACHES<br>HEARING PROBLEM<br>HEART CONDITION<br>HEARTBURN<br>HEPATITIS | HERNIA<br>HERNIATED DISC<br>HERPES<br>HIGH BLOOD<br>PRESSURE<br>HIGH<br>CHOLESTEROL<br>HYPERACTIVITY<br>INFERTILITY<br>KIDNEY DISEASE<br>LIGHT SENSITIVITY<br>LIVER DESEASE<br>LOSS OF BALANCE<br>MEASLES<br>MEMORY LOSS<br>MISCARRIAGE<br>MONONUCLEOSIS<br>MULTIPLE<br>SCLEROSIS<br>MUMPS<br>NECK<br>PAIN/STIFFNESS<br>NERVOUSNESS<br>OSTEOPOROSIS<br>PACEMAKER<br>PARKINSON'S<br>DISEASE<br>PINCHED NERVES<br>PINS AND NEEDLES | PNEUMONIA<br>POLIO<br>POOR POSTURE<br>PMS<br>PROSTRATE<br>PROLEMS<br>PROSTHESIS<br>PSYCHIATRIC<br>DISORDER<br>REFLUX<br>RHEUMATOID<br>ARTHRITIS<br>RHEUMATIC FEVER<br>SCARLET FEVER<br>SCOLIOSIS<br>SHORTNESS OF<br>BREATH<br>SKIN DISORDERS<br>SLEEPING<br>PROBLEMS<br>STOMACH<br>PROBLEMS<br>STROKE<br>SUICIDE ATTEMPT<br>THYROID<br>PROBLEMS<br>TONSILLITIS<br>TUBERCULOSIS<br>TUMORS/<br>GROWTHS<br>TYPHOID FEVER<br>ULCERS<br>VAGINAL<br>INFECTIONC<br>VISUAL PROBLEMS |

IF YOU HAVE A FAMILY HISTORY OF ANY OF THE ABOVE, PLEASE LIST THEM HERE: ___________________

__________________________________________________________________________________________

ARE YOU PREGNANT? YES_____ NO _____ DUE DATE: ___________
PREGNANCY RELATED SYMPTOMS?__________________________________________________________

**INJURIES/ SURGERIES. MEDICATIONS** **DESCRIPTIONS** **DATE**

FALLS/ACCIDENTS (AUTO OR PERSONAL): _________________________________ ___________________

HEAD INJURIES: ______________________________________________________ ___________________

BROKEN BONES/ DISLOCATIONS: ________________________________________ ___________________

SURGERIES: __________________________________________________________ ___________________

MEDICATIONS: _______________________________________________________ ___________________

I HAVE REVIEWED THE FOLLOWING INFORMATION ON THIS QUESTIONANAIRE AND IT IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THIS INFORMATION WILL BE USED BY THE CHIROPRACTOR TO HELP DETERMINED APPROPRIATE AND HEALTHFUL CHIROPRACTIC TREATMENT. IF THERE IS ANY CHANGE IN MY MEDICAL STATUS, I WILL INFORM DR. CAPUTO.

**PATIENT SIGNATURE/ LEGAL GUARDIAN SIGNATURE:**

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