Bruno Chiropractic Center

Medical History

Name_____

Date_____

1) Primary Complaint

2) Do you experience any numbness, tingling or radiating pain?

3) How/why did this happen?

4) Where did this happen?

5) When did this happen?

6) Where do you work?

7) What is your occupation/what does it consist of?

8) Are you out of work due to primary complaint?

9) How long of a disability—get dates?

10) Any previous tests for primary complaint (Xrays, MRI, CT scan), when and where?

11) Previous doctor's name and treatment for primary complaint? Did it help?

12) Any activity/position that relieves the symptoms?

13) Any activity/position that makes symptoms worse?

14) Have the symptoms been getting worse, same or improving?

15) Using heat or ice at home?

16) On a scale of 1-10, how would you rate your pain?

17) Are you taking any medication for this problem?

18) Are you allergic to any medication?

19) Any other health problems and are you taking medication for them?

Do you have diabetes?

Have you ever had a stroke?

Do you have cardiovascular disease?

Do you have hypertension?

20) Have you had any serious accidents, operations or illnesses?

Patient's Signature_____ Date_____ Dr. _____

DR. DAVID J. BRUNO

PATIENT INTRODUCTION FORM

TODAY'S DATE _____

SOCIAL SECURITY NO. _____ DATE OF BIRTH _____

NAME _____ MI _____ M __ F ____ HOME PHONE _____

ADDRESS _____ CITY: _____ ZIP: _____

MARITAL STATUS M____ W____ S____ D_____ NUMBER OF CHILDREN _____

EMPLOYER _____ BUSINESS PHONE _____

EMPLOYER'S ADDRESS _____ STATE: _____

OCCUPATION _____

NAME OF SPOUSE _____ OCCUPATION OR PROFESSION _____

HOW WERE YOU REFERRED TO THIS OFFICE? _____

HAVE YOU HAD CHIROPRACTIC CARE BEFORE? _____ WHERE? _____

TYPE OF INSURANCE COVERAGE: _____

_____ WORKMAN'S COMPENSATION _____ DATE OF INJURY

_____ LIABILITY _____ DATE OF INJURY

_____ ATTORNEY _____ ATTORNEY'S NAME

_____ PRIVATE OR GROUP POLICY _____ TYPE OF INSURANCE

_____ PRIVATE OR GROUP POLICY #

_____ MEDICARE _____ MEDICARE POLICY #

_____ BLUE CROSS PLAN 65 _____ PLAN 65 POLICY #

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understant that Dr. David J. Bruno will prepare any necessary reports and forms to assist me in making collection from the insurance company. However, I clearly understand and agree that all services rendered to me are to be charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. A monthly finance charge of 1½% will be added to any unpaid balance after 30 days.

PATIENT'S SIGNATURE _____

EMAIL: _____