



Welcome to the Chiropractic & Therapy Center!

1075 Easton Avenue Somerset, NJ ♦ (P) 732-545-5999 ♦ (F) 732-545-3439 ♦ chirtherapy@yahoo.com
Catherine Colaizzo, DC

Name: _____ Date: ____/____/____

Social Security #: _____ - _____ - _____ Date of Birth: ____/____/____ Age: _____ Male Female

Marital Status: S M D W Spouse: _____ Number of Children: _____

Address: _____

Home Phone: _____ - _____ - _____ Cell: _____ - _____ - _____ Work: _____ - _____ - _____ Ext: _____

Cell Carrier: _____ E-mail: _____

Occupation: _____ Employer: _____

Primary Care Physician: _____ Phone # of PCP: _____ - _____ - _____ May we contact? Y / N

Address of PCP: _____

Reason for today's visit: Emergency New Injury Old Injury Chronic Pain Wellness Date of Injury: ____/____/____

____/____/____

Major Complaint: _____

Other Complaints: _____

Aggravating Factors? _____

Alleviating Factors? _____

Headaches: Y / N Frequency: ____/week How long has it been since you felt really good? _____

List any diagnosis and treatment for this condition: _____

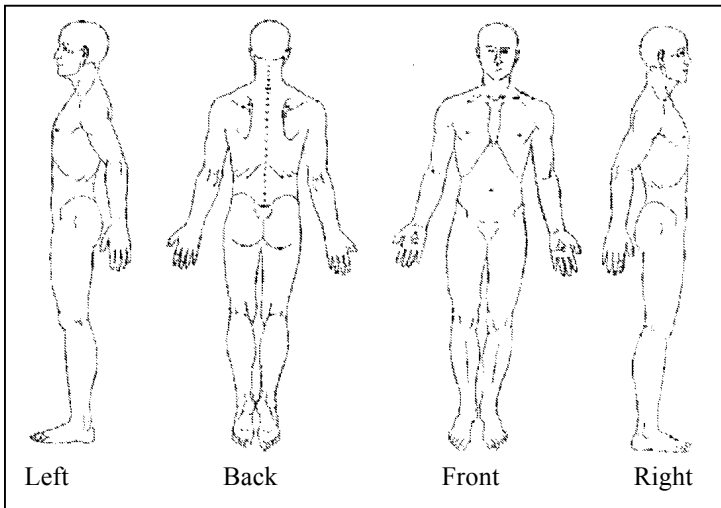
Bone Fracture: Y / N What bones? _____ Ever been knocked unconscious? Y / N Date of Injury: ____/____/____

List any surgical procedures: _____

List prescriptions/OTC meds/supplements, herbs: _____

Using body chart below, please X all affected areas:

Please indicate: Heavy, moderate, light, or none:



Alcohol: H M L N Coffee: H M L N
Tobacco: H M L N Exercise: H M L N
Sleep: H M L N Appetite: H M L N

People go to Chiropractic for a variety of reasons; some for symptomatic relief of pain or discomfort (relief care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (corrective care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with chiropractic care (comprehensive care). Please circle one of the following:

Relief Care

Corrective Care

Comprehensive Care

Let Doctor Select

Please indicate with an X the average intensity of your symptoms:

Who may we thank for referring you to our office? _____



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The insurance company, _____, covers chiropractic services but on a very limited basis. You are allowed _____ visits per calendar year. It does not cover services chiropractors are licensed and trained to perform such as:

X-rays, examinations, interferential electrical stimulation, ultrasound, ART (active release care), manual soft tissue therapy, massage, muscle work, neuromuscular re-education, stretching, active exercises, general nutritional counseling, and durable supplies such as cervical pillows and Biofreeze.

Note to Medicare Patients: even if you have AARP as additional insurance, these services will not be covered as AARP only covers charges approved by Medicare. However, coverage from a secondary insurance company may assume the costs.

In order to administer appropriate, quality chiropractic care some or all of the above services will be needed to be performed. This letter is to inform you of your benefits prior to receiving services. All non-billable services will be your responsibility. This is in addition to your co-pay/co-insurance of \$ _____ / _____ % per visit.

Non-billable Exam Fee \$ _____	Non-billable X-rays \$ _____
Additional therapies \$ _____	Co-pay/Coinsurance \$ _____ / _____ %
Total fee per visit \$ _____	

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided. I hereby assign my insurance benefits to be paid directly to the Chiropractic & Therapy Center and acknowledge that I am financially responsible for any non-covered services. I hereby authorize my physician to release any information required to support my claim.

Print Name: _____

Signature: _____

Date: ____/____/____

Adult Patient Parent/Guardian Spouse