Dr. Orienda Piccinini, D.C.
44150 12 Mile Rd. Suite 100
Novi, MI 48377
(248)924-9733
drorienda@freshstartchiropractic.com

**Confidential Health Information**

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# ADULT HEALTH HISTORY FORM

Please fill out this form as completely and accurately as possible.

Today's Date_____ Patient Number (office use only) _____

## PERSONAL INFORMATION

Name _____ Age _____ Date of Birth _____

**Parent's names (if you are under 18)**

_____

**Whom may we thank for referring you to our office?**

_____

Home Address_____City _____ State_____ Zip _____

Home Phone (____) _____ Business Phone (____) _____

Cell Phone (____) _____E-mail address _____

Occupation_____Employer _____

Business Address_____ City_____State_____ Zip _____

Preferred Method of Contact ❑ Home phone ❑ Work phone ❑ Cell phone ❑ Email

SS# (opt'l)_____ Emergency contact _____

Emergency Contact Phone _____ Gender ❑ Male ❑ Female

Race _____ Ethnicity _____ Preferred Language _____

Marital Status ❑ S ❑ M ❑ D ❑ W ❑ L/W Spouse/Partner _____

Names and Ages of Children

_____

Primary Care Provider: _____

Insurance Carrier: _____ Policy Number: _____

Insured's Last Name: _____ Insured's First Name: _____

Birth Date (MM/DD/YYYY): _____ Who carries this policy? ❑ Self ❑ Spouse ❑ Parent

Insured's Employer _____

Address _____ City _____

State _____ Zip/Postal Code _____ Employer's Phone _____

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## REASON FOR SEEKING CHIROPRACTIC CARE

1. **What concerns do you feel Fresh Start Chiropractic can address for you?**

_____

2. **Are your concerns a result of**: ❑ An accident or injury

   ❑ Work ❑ Auto ❑ Other

   ❑ A worsening long-term problem

   ❑ An interest in: ❑ Wellness ❑ Other _____

3. **Onset (When did you first notice your current symptoms?)** _____

4. **Intensity (How extreme are your current symptoms?)**

   ❑ 0 (absent) ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 (uncomfortable) ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 (Agonizing)

5. **Duration and Timing (When did it start and how often do you feel it?)**

   When did it start? _____ How often? _❑ Constant ❑ Comes and Goes

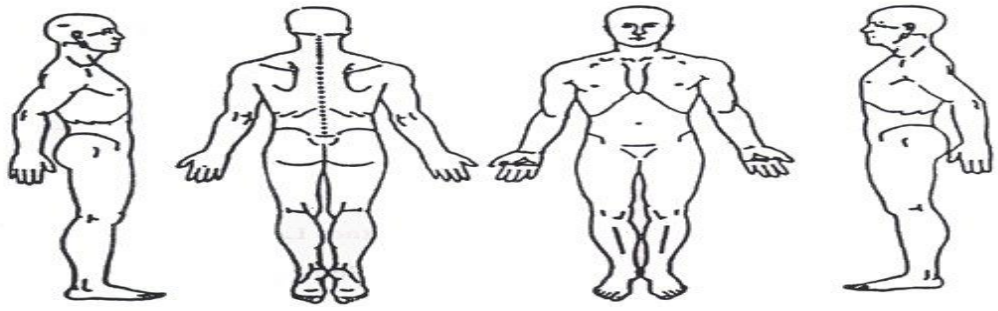
   _____ _____ _____

6. **Quality of Symptoms (What does it feel like?)** ❑ Numbness ❑ Tingling ❑ Stiffness ❑ Dull

   ❑ Achy ❑ Cramps ❑ Nagging ❑ Sharp ❑ Burning ❑ Shooting ❑ Throbbing ❑ Stabbing

   ❑ Other

7. **Location (Where does it hurt?) "x' for current conditions**



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8. **Radiation** **(Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?)**

_____

9. **Aggravating or Relieving Factors** **(What makes it better or worse, such as time of day, movements, certain activities, etc.)**

What tends to make the problem worse? _____

What tends to make the problem better? _____

10. **Prior Intervention** **(What have you done to relieve the symptoms?)**

❑ Homeopathic Remedies ❑ Physical Therapy ❑ Acupuncture ❑ Chiropractic ❑ Massage

❑ Ice ❑ Heat ❑ Over the counter drugs ❑ Prescription medication ❑ Surgery

❑ Other

11. **Are these concerns affecting your quality of life?** **(Please circle only those applicable to you)**

Work: Y N Driving: Y N Sleep: Y N
School: Y N Walking: Y N Sitting: Y N
Exercise/sports: Y N Eating: Y N Love life: Y N

## MEDICAL HISTORY

1. **Have you ever received Chiropractic care?** ❑Y ❑ N Name of D.C_____

How long were you under care? ❑ _____ days ❑_____ weeks ❑_____ months ❑ ____ years

Date of last visit: _____Why did you stop? _____

2. **Have you consulted or do you regularly consult any of the following providers?** (check all that apply)

❑ Medical Physician ❑ Naturopath ❑ Acupuncturist ❑ Homeopath ❑ PT

❑ Massage Therapist ❑ Psychotherapist ❑ Energy HealeR ❑ Dentist ❑ Optometrist

Reason why: _____

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**3. Review of Systems** **(Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please check the box beside any condition that you've HAD or currently HAVE and initial to the right.)**

**a. Musculoskeletal** ❑ None Initials _____

| Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | Osteoporosis | ❑ | ❑ | Arthritis | ❑ | ❑ | Scoliosis |
| ❑ | ❑ | Knee Injuries | ❑ | ❑ | Foot/ankle pain | ❑ | ❑ | Shoulder problems |
| ❑ | ❑ | Neck pain | ❑ | ❑ | Back problems | ❑ | ❑ | Hip disorders |
| ❑ | ❑ | Elbow/ Wrist pain | ❑ | ❑ | TMJ issues | ❑ | ❑ | Poor posture |

**b. Neurological** ❑ None Initials _____

| Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | Anxiety | ❑ | ❑ | Depression | ❑ | ❑ | Headache |
| ❑ | ❑ | Dizziness | ❑ | ❑ | Pins & Needles | ❑ | ❑ | Numbness |

**c. Cardiovascular** ❑ None Initials _____

| Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | High blood pressure | ❑ | ❑ | Low blood pressure | ❑ | ❑ | High cholesterol |
| ❑ | ❑ | Poor circulation | ❑ | ❑ | Angina | ❑ | ❑ | Excessive Bruising |

**d. Respiratory** ❑ None Initials _____

| Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | Asthma | ❑ | ❑ | Apnea | ❑ | ❑ | Emphysema |
| ❑ | ❑ | Hay Fever | ❑ | ❑ | Shortness of breath | ❑ | ❑ | Pneumonia |

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**e. Digestive** ❑ None Initials _____

| Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | Anorexia/ Bulimia | ❑ | ❑ | Ulcer | ❑ | ❑ | Food sensitivities |
| ❑ | ❑ | Heartburn | ❑ | ❑ | Constipation | ❑ | ❑ | Diarrhea |

**f. Sensory** ❑ None Initials _____

| Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | Blurred Vision | ❑ | ❑ | Ringing in ears | ❑ | ❑ | Hearing loss |
| ❑ | ❑ | Chronic ear Infection | ❑ | ❑ | Loss of smell | ❑ | ❑ | Loss of taste |

**g. Skin** ❑ None Initials _____

| Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | Skin cancer | ❑ | ❑ | Psoriasis | ❑ | ❑ | Eczema |
| ❑ | ❑ | Acne | ❑ | ❑ | Hair loss | ❑ | ❑ | Rash |

**h. Endocrine** ❑ None Initials _____

| Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | Thyroid issues | ❑ | ❑ | Immune disorders | ❑ | ❑ | Hypoglycemia |
| ❑ | ❑ | Frequent infection | ❑ | ❑ | Swollen glands | ❑ | ❑ | Low energy |

**i. Genitourinary** ❑ None Initials _____

| Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | Kidney stones | ❑ | ❑ | Infertility | ❑ | ❑ | Bedwetting |
| ❑ | ❑ | Prostate issues | ❑ | ❑ | Erectile Dysfunction | ❑ | ❑ | PMS |

**j. Constitutional** ❑ None Initials _____

| Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | Fainting | ❑ | ❑ | Low libido | ❑ | ❑ | Poor appetite |
| ❑ | ❑ | Fatigue | ❑ | ❑ | Sudden weight changes | ❑ | ❑ | Weakness |

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## FOR WOMAN

**Are you pregnant?** Y N Date of last menstrual period: _____

If x-rays are recommended, your signature is required (below) to indicate that you are **not pregnant**.

Signature:_____Date:_____

If **pregnant**, Due Date: _____ Name of OBGYN or Midwife: _____

Where will you be birthing your baby? ❑ Hospital ❑ Home ❑ Birthing Center ❑ Other _____

## PHYSICAL, EMOTIONAL, & CHEMICAL STRESS

The vertebrae, (bones of the spinal column) surround and protect the delicate NERVE SYSTEM. Chiropractors are specialists trained in "early detection" of injury to the SPINE & NERVE SYSTEM.

The information below will help us to see the types of PHYSICAL, EMOTIONAL & CHEMICAL stresses you have been subjected to and ***how they may relate to your present spinal, nerve and* health *status.***

## PHYSICAL STRESS: BIRTH AND INFANCY

The birth process can traumatize a baby's spine and cause damage to the spine & nerve system. Please indicate where and how you were birthed. (If you do not know, please skip to next question)

| | | | | |
|---|---|---|---|---|
| ❑ Home | ❑ Natural | ❑ Hospital | ❑ Caesarian section | ❑ Forceps |
| ❑ Breech | ❑ Cord around neck | ❑ Prolonged labor | ❑ Drug induced labor | ❑ Suction |

## PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list. Please list the major traumas that you remember from your childhood up to the present.

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Have you had any **accidents or injuries in your life** related to any of the following? (check all that apply)

❑ Automobile ❑ Motorcycle ❑ Bicycle ❑ Sports ❑ Playground ❑ Abuse

If yes, state ***type of injury and date:***

_____

_____

Have you ever **hurt/injured your** spine, head, neck, ribs, chest, upper or lower back, pelvis or hips?
❑ Y ❑ N

If yes, state ***type of injury and date:***

_____

_____

Have you ever **hurt, broken, fractured or sprained** any bones or joints? ❑ Y ❑ N

If yes, list ***body parts injured and dates:***

_____

_____

Have you ever been hospitalized? ❑ Y ❑ N
If yes, ***state reason and dates:***

_____

## EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have experienced any of the emotional stresses below:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Childhood Trauma | Y | N | Loss of loved one | Y | N | Abuse | Y | N |
| Work or School | Y | N | Divorce/separation | Y | N | Financial | Y | N |
| Lifestyle change | Y | N | Parents divorce | Y | N | Illness | Y | N |

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## CHEMICAL STRESS

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Were you **vaccinated?** ❑ Y ❑ N If yes, did you have a **reaction**? ❑ Y ❑ N

Have you been **exposed to** any of the following on a regular basis, (past or present)?

❑ Toxic chemicals ❑ Second hand smoke ❑ Drug therapy
❑ Radiation ❑ Chemotherapy ❑ Other

If yes, please list: _____

Do you have **allergies** to any foods? ❑ Y ❑ N

**If yes, please list:** _____

Do you **consume** any of the following presently?

❑ Coffee/caffeine ❑ Alcohol ❑ Tobacco ❑ Over the counter drugs ❑ Prescribed drugs

Please list all medications (prescribed and over the counter):

_____

## QUALITY OF LIFE

How do you grade your **physical health**? ❑ Good ❑ Fair ❑ Poor

How do you grade your **emotional/mental health**? ❑ Good ❑ Fair ❑ Poor

How do you rate your overall **"quality of life"**? ❑ Good ❑ Fair ❑ Poor

Do you **exercise** regularly? If yes, how often? _____

Do you take **supplements**? If yes, please list:_____

Do you follow a **special dietary regime**? If yes, what? _____

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## EXPECTATIONS

I would like to have the following benefits from ***Chiropractic Care***: (Check all that apply)

- ❒ Relief of a symptom or problem
- ❒ Relief and Prevention of a symptom or problem
- ❒ Healthier spine and nerve system
- ❒ Optimal health on all levels

## CHIROPRACTIC CLINICAL OBJECTIVE

Physical, Emotional and Chemical STRESSES, common to our contemporary lifestyles, can result in misalignment of the spinal column causing damage to the nerve system. The result is a condition called Vertebral Subluxation. The Chiropractic Exam/evaluation is specifically designed to detect Vertebral Subluxations in all phases of their progression.

## FINANCES/INSURANCE

Payment in full is expected on all FIRST VISIT services (whether you have insurance coverage or not). All other fees are to be paid at time of service until other arrangements have been made and agreed upon in writing.

Please indicate your method of payment. ❑ Cash ❑ Credit Card

**First Visit Fees: Comprehensive Exam & Adjustment: $_____ X-Rays (if needed):_____**

Please indicate below, the name of your insurance company.

**Health Insurance Co**:

_____

**If you have Medicare, we will need a copy of your insurance card.**

**If this is an Auto Accident or a Work-Related injury, please provide us with the following information:**

Name of Auto Insurance Co: _____

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Have you been treated elsewhere? ❑ Emergency Room ❑ Primary Care Doctor ❑ Other

What services were provided? ❑ MRI ❑ X-Rays ❑ Medication ❑ Therapy

## READ AND SIGN BELOW

1. I have been informed that a copy of Fresh Start Chiropractic's *"Notice of Privacy Practices for Protected Health Information (HIPAA)"* brochure is available for my review.
2. I consent to receive communication from FSC via email, postal mail, text and telephone messaging in connection with my care. ❑ Yes ❑ No If I should withdraw my consent, I will notify the office in writing.
3. I consent to my name (first name, last initial) being posted on the Referral Board when I refer a new patient to FSC. ❑ Yes ❑ No If I should withdraw my consent, I will notify the office in writing.
4. I clearly understand and agree that all services rendered will either be charged to me or my insurance company, whichever written arrangement I have made with Dr. Orienda Piccinini. If I choose to have my insurance billed I agree to pay any co-pay, co-insurance, or office call fee. If I choose not to bill insurance I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if my care is suspended or terminated, any fees for professional services rendered will become immediately due and payable.
5. I hereby authorize assignment of insurance rights and benefits (if applicable) directly to the provider for services rendered to me.

*The information I have provided, on this case history form, is true and accurate, to the best of my knowledge. I give Dr. Orienda Piccinini permission to render care to me today. This initial visit includes a health history/consultation, chiropractic exam/evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.*

Signature_____ Today's Date_____

Signature of Parent (for minor):_____ Today's Date_____

***Thank you for choosing Fresh Start Chiropractic.***
***We look forward to helping you.***