Dr. Jeanette Altieri
Dr. Louis Cavallo

AC CHIROPRACTIC LIFE CENTER
Est. 1992

Specializing In:
Pediatrics
Pregnancy
Family Care
Sports Performance

Adult Patient Information **Male ____ Female____ Date** _____

Name _____ Street _____

City _____State ____ **Zip** _____ Age _____ Birth date _____-_____-_____

Home Phone _____ Cell Phone _____ Marital Status: S[] M[] D[] W[]

Occupation _____ Employer _____Address _____

Office Phone _____ Referred by _____ Date last physical exam _____

E-mail address _____

Name of spouse _____ Name(s) of children _____

Purpose of this visit? _____ Social Security #: ____-___-____

Other Dr(s) seen for condition _____ Spouse's SSN: ____-____-_____

Have you ever received chiropractic care before? Y/N ***Explain:*** _____

Health history – List any accidents/ operations/ broken bones and their dates: _____

_____

Are you pregnant? Y/N Date of last menstruation _____

Were you involved in a work-related accident? [] Yes [] No When? _____

Were you involved in an automobile accident? [] Yes [] No When? _____

If you answered Yes to either of these, please skip to reverse side of form.

Please check ANY SYMPTOMS YOU ARE EXPERIENCING:

[] Headaches	[] Dizziness	[] Lights bother eyes	[] Loss of memory	[] Chronic colds
[] Neck pain	[] Ears ringing/buzzing	[] Fainting	[] Loss of smell	[] Cold sweats
[] Back pain	[] Ear infection	[] Head seems heavy	[] Loss of balance	[] Shortness of breath
[] Nervousness	[] Pins/needles in arms	[] Fatigue	[] Loss of taste	[] Bedwetting
[] Tension	[] Numbness in fingers	[] Depression	[] Sleeping problems	[] Fever
[] Irritability	[] Numbness in toes	[] Allergies	[] Constipation	[] Cold Feet
[] Chest pain	[] Cold hands	[] Sinus infection	[] Diarrhea	[] Asthma

[] Other _____

Do any of your children or spouse suffer from any of the above symptoms? [] Yes [] No
Explain: _____

Insurance Information **(must be completed)**

Name of insured _____ Insured's employer _____
Birthdate of insured _____ Deductible amount _____ Has deductible been met? [] Yes [] No
Insured's ID# _____ Person responsible for payment _____
Driver's license # _____ State _____

I understand that AC CHIROPRACTIC LIFE CENTER, P.C. will prepare any necessary forms to assist me in submitting claims to my insurance provider and credit my account when payment is received. However, I clearly understand that all services rendered to me are charged directly to me and I am personally responsible for payment unless other arrangements have been made.

PATIENT SIGNATURE _____ **DATE** _____