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Name _____ Date _____

Social Security Number _____ Date of Birth _____ Age _____

Address _____

City, State, Zip Code _____ Home Phone # _____

Cell Phone # _____ Email Address _____

Married Single Divorce Widowed Engaged Domestic Partner

Children Yes No If yes, how many son(s) _____ daughter(s) _____

Emergency Contact _____ Relationship _____

Home Phone # _____ Cell Phone # _____ Work# _____

Employer _____ Occupation _____

Employer's Address _____

City, State, Zip Code _____ Work Phone # _____

Whom May We Thank For Referring You?: _____

Insurance Information

Insurance Carrier _____

ID# _____ Group # _____

Authorization for Release of Medical Records to Spouse, Parent, Guardian, or other (please specify)

I, _____ give express written consent to the physician(s) and staff of this practice to disclose health information pertaining to my health and medical records to _____ who is spouse/friend/parent/guardian.

Assignment and Release:

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to Dr. Rivano all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when treatment is no longer rendered at the office named above or one year from the date signed below.

_____ Date: _____

Signature of Patient, Parent, Guardian or Personal Representative

Print Name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Name:



Date:

Male Female Hand Dominance Right Left Height _____ Weight _____

Primary Chief Complaint _____

What specific body region(s) is affected? _____

Secondary Complaint _____

What specific body region(s) are affected? _____

When did your **symptoms initially begin**? Be as specific as you can with regard to **time and place**. _____

Was there a **specific mechanism of injury**? Yes No If Yes, please check off one of the following:

<input type="checkbox"/> Trauma	<input type="checkbox"/> Fall	<input type="checkbox"/> Car Accident	<input type="checkbox"/> Athletic Injury	<input type="checkbox"/> Accident
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What is the pain **frequency**?: Constant - 100% Frequent - 75% Intermittent - 50% Occasional - 25%

Is the **severity**: Mild Mild to Moderate Moderate Moderately Severe Severe

Is the pain getting progressively worse? Yes No How long does the pain last? _____

Is the pain present **10%, 20%, 30%, 40%, 50%, 60%, 70%, 80%, 90% or 100%** of the **day, week, month**?

What makes the **pain worse**? _____

What makes the **pain better**? _____

What **type of pain** are you experiencing? (**check all that apply**)

<input type="checkbox"/> Aching	<input type="checkbox"/> Boring	<input type="checkbox"/> Burning	<input type="checkbox"/> Cramping	<input type="checkbox"/> Deep	<input type="checkbox"/> Dull	<input type="checkbox"/> Heaviness
<input type="checkbox"/> Numbness	<input type="checkbox"/> Pins & Needles	<input type="checkbox"/> Radiating	<input type="checkbox"/> Sharp	<input type="checkbox"/> Spasming	<input type="checkbox"/> Shooting	<input type="checkbox"/> Stabbing
<input type="checkbox"/> Stiffness	<input type="checkbox"/> Swelling	<input type="checkbox"/> Throbbing	<input type="checkbox"/> Tingling	<input type="checkbox"/> Weakness	<input type="checkbox"/> Stiffness	

If the pain **Radiates (travels)**, describe where it radiates to: _____

Does it interfere with (**check all that apply**):

<input type="checkbox"/> Daily Routine	<input type="checkbox"/> Recreation	<input type="checkbox"/> School	<input type="checkbox"/> Sex Life	<input type="checkbox"/> Sleep	<input type="checkbox"/> Social Life	<input type="checkbox"/> Work
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Which **activities or movements are painful** to perform (**check all that apply**)?

<input type="checkbox"/> Bending	<input type="checkbox"/> Climbing Stairs	<input type="checkbox"/> Coughing	<input type="checkbox"/> Doing Housework	<input type="checkbox"/> Doing Laundry
<input type="checkbox"/> Doing Yard Work	<input type="checkbox"/> Driving	<input type="checkbox"/> Exercising	<input type="checkbox"/> Getting Dressed	<input type="checkbox"/> Getting In/Out of Vehicle
<input type="checkbox"/> Lying on Back	<input type="checkbox"/> Lying Down	<input type="checkbox"/> Lying on Side	<input type="checkbox"/> Lying on Stomach	<input type="checkbox"/> Reaching Overhead
<input type="checkbox"/> Sitting	<input type="checkbox"/> Sleeping	<input type="checkbox"/> Sneezing	<input type="checkbox"/> Squatting	<input type="checkbox"/> Standing
<input type="checkbox"/> Turning Head While Driving	<input type="checkbox"/> Using a Computer	<input type="checkbox"/> Using the Bathroom	<input type="checkbox"/> Walking	

Name:



Date:

Rate the severity of your pain on a numeric scale of 1 (least amount of pain) to 10 (severe pain): _____

Is the pain worse in the: Morning Afternoon Night

List any medication(s) you are currently taking and what dosages if known?

Are you allergic to any medications? Y N If yes, which ones _____

Please provide us with the name and telephone number of your primary care doctor: _____

Have you seen any other healthcare provider for this condition? Please provide their name and telephone number:

Past Medical History

Have you ever suffered from this type of condition in the past? Y N If yes, when did it occur last and what did you do for it? _____

Did it resolve on its own or did you see someone for the condition? _____

List any surgeries and the dates they were performed below:

Type of Surgery	Reason For Surgery	Date of Surgery

Have you ever been hospitalized? Y N If yes, when and why _____

Have you broken any bones? Y N If yes, which bones and when? _____

Have you ever experienced any previous accidents? If so, briefly explain _____

Do you suffer from any pre-existing conditions related or unrelated to your current complaint? _____

Have you suffered any head injuries? _____ If so, briefly explain _____

Name:



Date:

*** Please check off any of the following conditions that you've had in the past or currently suffer with.***
Indicate the date you were diagnosed with each condition on each line item

Table with 4 columns and 20 rows of medical conditions, each with a checkbox.

Family History

Are both of your parents alive and well? [] Y [] N If not, what condition(s)/impairment(s) if any, did they suffer from?

Has either of your parents suffered from the same or similar condition that you are suffering from today? [] Y [] N

Do you or does anyone in your family suffer from diabetes, heart disease, or cancer? [] Y [] N

Social History

Exercise: How many times per week and for how long? _____

Do you use free weights? _____ Do you do cardio? _____

List any recreational activities that you participate in: _____

Do you take vitamins or supplements? [] Y [] N If yes, please list them: _____

Alcohol use: How many drinks per week? _____

Tobacco usage: How many packs per day? _____

Do you drink any caffeinated beverages? [] Y [] N, If yes, how many per day? _____

Have you ever used recreational drugs? [] Y [] N, If yes, which ones? _____

What are you unable to do now because of your condition that you'd like to be able to do? _____

Name:



Date:

What are your **short term and long term goals** for receiving care at this office? _____

List region of pain and **circle severity number on diagram** below. (1 = least, 10 = greatest)

Mark Pain Region Using Symbols

Achy (AAA), Burning (+++), Constant (!!!), Dull (<<<), Pins & Needles (*), Sharp (###), Stabbing (XXX)**

Regions

Neck:	1 2 3 4 5 6 7 8 9 10
Mid Back:	1 2 3 4 5 6 7 8 9 10
Lower Back:	1 2 3 4 5 6 7 8 9 10
Hips:	1 2 3 4 5 6 7 8 9 10
Arms:	1 2 3 4 5 6 7 8 9 10
Legs:	1 2 3 4 5 6 7 8 9 10
Feet:	1 2 3 4 5 6 7 8 9 10

Please mark the area of pain on the drawing using the code listed above

