Last Name:

15 Village Square, Suite 1
New Hope, PA 18938
215.693.1176

Welcome to Functional Life

Welcome to our office! Rest assured that you will be provided the most appropriate and professional healthcare possible. Our most important goal is the constant improvement and maintenance of your health. Before we get started with your examination procedures, which will determine if we can help you, we want you to understand what we do and why we are going to do it.

When a person seeks our care and when we accept a patient for such care, it is essential that we are both working towards the same goals. The goal of our office is to allow your body to function at its highest potential, free from interference and stress that causes dysfunction, disease, and eventually symptoms and sickness. Most importantly, you must understand that our care is not a substitute for medical treatment of any kind, in anyway, or for any reason. The medical approach treats symptoms and diagnoses conditions and diseases. Patients usually go to their medical doctors to get rid of whatever symptoms or conditions are bothering them. This is symptom, sickness and disease care and is necessary in emergency situations. Our approach recognizes that you get symptoms for a reason, attempts to find the cause of the symptoms, and addresses the function of the whole body. This is how we define healthcare; focusing on the optimum function of the individual, and it is what we do it in our office.

We provide various services in our office including Chiropractic care, massage therapy, exercise therapy and nutritional services. The purpose of Chiropractic care is to restore and maintain the integrity of the spine, spinal cord and its nerve roots. Vital nerve pathways are housed within and protected by the bones of the spine called vertebrae. Misalignments of those vertebrae, which interfere with transmission of normal nerve impulses, are called SUBLUXATIONS. Subluxations are the most common cause of nerve system interference (pinched nerve) and cause dysfunction to the tissue and organs that these nerves supply. With appropriate Chiropractic care, these subluxations can be reduced and corrected, which will restore normal nerve function. A properly functioning nerve system is the foundation to good health.

The information we get from you on the following pages is important. For this reason, please fill out our history forms completely and to the best of your ability so that we can quickly get you on the road to health. We look forward to a healthy relationship with you and your family.

I, __________________________________, have read the above, understand it.

Last Name:

Date: ____________________ Social Security #____

Name: ____
Last First M.I

Address_____________________________________City_________________________State________ Zip _______

E-mail (please provide for communication purposes) ____

Cell Phone: ______________________________ Home Phone: _____________________________

Sex: ______Male ______ Female Age: __________ Birthdate: _________________

___Married ____Separated ____Widowed ____Divorced ____Single ____Partnered for ___Yrs ____Minor

Preferred method of communication: (Check one) Email___ Text___ + Carrier Name ___________ Phone ________

Preferred Language: ____________________ Ethnicity (Circle): Hispanic or Latino / Not Hispanic or Latino/ Decline

Race (Circle): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) /
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Patient Employer/School ____

Address: ____

Phone: ____ Occupation: ____________________________________

Spouse's Name: ____________________________ SS#______ - ______ - _________ Phone: _________________

Birthdate: ________________ Spouse's Employer: ____

Emergency Contact: _______________________________ Relationship: __________________ Phone_____________

ACCIDENT INFORMATION: Is condition due to an accident? Yes____ No____ Date of Accident ___________
Type of Accident: Auto ____ Work ____ Home____ Other ____

INSURANCE INFORMATION:

Who is responsible for this account? ____________________ Relationship to patient: ___________________________

Insurance Co: ____ ID#_______________________________________

Subscriber Name ____ Birthdate: _________________________________

ASSIGNMENT AND RELEASE: I certify that I, and/or my dependent(s), have insurance coverage with ____ and assign directly to Dr. Eric Pirrone, 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 my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative Date

____
Please print name of above signature Relationship to Patient

Last Name:

Financial Responsibility

Patient Name____

Dear Patient,
Dr. Eric Pirrone provides its services directly to you, not to your insurance company. You are ultimately liable for your bill. If you are billing your own claims, we will provide you with an itemized bill. However, as a courtesy to you, we will bill your insurance company for services rendered provided that your deductible has been met and you pay your co-payment at the time of service. In the event that we are billing your insurance company and a check is mailed to you, you MUST bring the check into the office within 7 days so that we may properly credit your account.
I have read and understood all the above information.

___________________________________ __________
Patient Signature Date

X-Ray Consent

I hereby give my consent to Dr. Eric Pirrone and its representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am not pregnant.
I have read and understood all the above information.

___________________________________ __________
Patient Signature Date

Clinical Summary (a required EMR question)

___ I choose to decline receipt of my clinical summary after every visit *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

FUNCTIONAL LIFE
FNX.LIFE

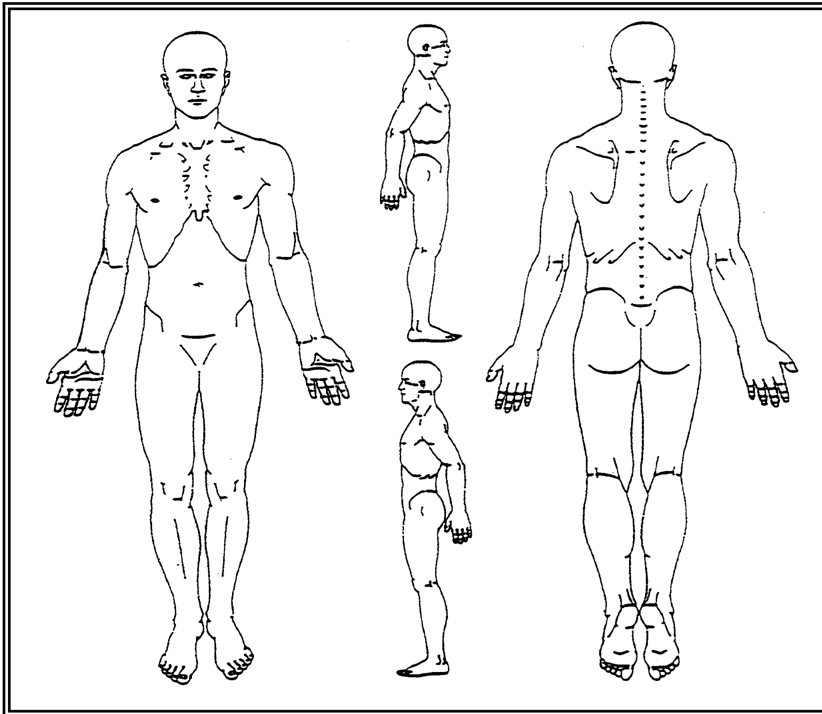
Last Name:

Please let us know who we can thank for referring you to our office: ______________________________________

Please indicate the main reason you are seeing us today: ____

If you are seeing us for a pain related issue, use the symbols to show what type of pain you feel on the diagram.

XXXXXXXXX	/ / / / / / / / / / /	o o o o o o o o o o	s s s s s	- - - - - - - -
DULL/ACHY	**SHARP/STABBING**	**NUMBNESS/TINGLING**	**STIFF/TIGHT**	**BURNING**



Using the pain scale below, circle the pain level you experience when this problem is at its very worst:

0 = No Pain. No Discomfort
1 = Minimal Discomfort. Minor stiffness or tightness.
2 = Discomfort. Stiff, tight, sore. Muscle fatigue.
3 = Minimal Pain. More than just sore. Uncomfortable.
4 = Mild Pain. Noticeable pain but tolerable.
5 = Moderate Pain. Aggravating. Still allows movement.
6 = Strong Pain. Quite aggravating. Movement slightly limited.
7 = Very Strong Pain. Very aggravating. Movement definitely limited.
8 = Very, Very Strong Pain. Extremely aggravating. Movement very limited.
9 = Severe Pain. Brings tears. Almost impossible to move.
10 = Excruciating Pain. Agony. Unbearable. Cannot move. ER.

Do you have any other health conditions, regardless of whether you think it's related to your spine:
____
____
____

Is there any radiating pain into the arms or legs? ___________ **Is there any numbness or tingling?** ________________

How long have you been suffering with this problem, has it been more than a month or two? ____________________

Last Name:

REVIEW OF SYMPTOMS

Please use the 1 to 4 guide below to rate each of the symptoms on this page according to your health status over the past 30 days. Enter 0 (or leave blank) if you never have had, or a symptom is not applicable to you.

1 - Occasionally have it, effect is not severe
2 - Occasionally have it, effect is severe
3 - Frequently have it, effect is not severe
4 - Frequently have it, effect is severe

HEAD _____Headaches _____Faintness _____Dizziness _____Insomnia Total_______	**ENERGY/ACTIVITY** _____Fatigue, Sluggishness _____Apathy, Lethargy _____Hyperactivity _____Restlessness Total_______	**LUNGS** _____Chest Congestion _____Asthma, Bronchitis _____Shortness of Breath _____Difficulty Breathing Total_______
EYES _____Watery or Itchy Eyes _____Swollen, Reddened or Sticky Eyelids _____Bags or Dark Circles Under Eyes _____Blurred or Tunnel Vision (does not include near or far-sighted) Total_______	**WEIGHT** _____Binge Eating/Drinking _____Craving Certain Foods _____Excessive Weight _____Compulsive Eating _____Water Retention _____Underweight Total_______	**HEART** _____Irregular or Skipped Heartbeat _____Rapid or Pounding Heartbeat _____Chest Pain Total_______
EARS _____Itchy Ears _____Earaches, Ear Infections _____Drainage from Ear _____Ringing in Ears, Hearing Loss Total_______	**EMOTIONS** _____Mood Swings _____Anxiety, Fear, Nervousness _____Anger, Irritability, Aggressiveness _____Depression Total_______	**DIGESTIVE TRACT** _____Nausea, Vomiting _____Diarrhea _____Constipation _____Bloated Feeling _____Belching, Passing Gas _____Heartburn _____Intestinal/Stomach Pain Total_______ **OTHER** _____Frequent Illness _____Frequent or Urgent Urination _____Genital Itch or Discharge Total_______
NOSE _____Stuffy Nose _____Sinus Problems _____Hay Fever _____Sneezing Attacks _____Excessive Mucus Formation Total_______ **MOUTH/THROAT** _____Chronic Coughing _____Gagging, Frequent Need to Clear Throat _____Sore Throat, Hoarseness, Loss of Voice _____Swollen or Discolored Tongue, Gums/Lips _____Canker Sores Total_______	**MIND** _____Poor Memory _____Confusion, Poor Comprehension _____Poor Concentration _____Poor Physical Condition _____Difficulty in Making Decisions _____Stuttering or Stammering _____Slurred Speech _____Learning Disabilities Total_______	
SKIN _____Acne _____Hives, Rashes, Dry Skin _____Hair Loss _____Flushing, Hot Flashes _____Excessive Sweating Total_______	**JOINTS/MUSCLE** _____Pain or Aches in Joints _____Arthritis _____Stiffness or Limited Movement _____Pain or Aches in Muscles _____Feeling of Weakness or Tiredness Total_______	**GRAND TOTAL** ________

Last Name:

PAST MEDICAL HISTORY

Please list any significant conditions that you've been diagnosed with or been treated for over the course of your life: _________

____

Please list any surgeries you have had over the course of your life: ____

____

MEDICATIONS & ALLERGIES

Are you allergic to any medications? ☐Yes ☐No - **If yes, please list:** ____

List any medications you are taking: ____

____

FAMILY HISTORY

Mother: ☐Living ☐Deceased List any medical problems: ____

Father: ☐Living ☐Deceased List any medical problems: ____

List any problems common in your family: ☐Cancer ☐Diabetes ☐Heart disease ☐High blood pressure ☐Stroke ☐Arthritis ☐Scoliosis ☐Thyroid disease ☐Osteoporosis ☐ Other ____

SOCIAL HISTORY

Do you have any children? ☐Yes ☐No If yes, how many? ____

Do you drink alcohol? ☐Yes ☐No If yes, how much & how often? ____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

PERSONAL HEALTH GOALS

☐Improve Nutrition/Eating Habits	☐Lower Cholesterol	☐Get off Medications
☐Weight Loss/Fat Loss	☐Lower Blood Pressure	☐Improved Sleep
☐Increase Lean Muscle Mass	☐Start Exercising	☐Improved Energy
☐Increase Bone Density	☐Look Better	☐Improved Posture
☐Reduce Stress	☐Feel Better	☐Improved Outlook/Happiness

On a scale of 1 to 10 with 1=Poor and 10=Excellent, please rate how well you think you are doing in the following categories:

Exercise________ **Sleep** ________ **Diet** _________ **Stress Level** _______ **Water Intake** ________ **Energy Level**__________

Do you take: Omega 3 (Fish Oil)? Yes - No Vitamin D3? Yes - No Probiotics? Yes - No

Who is your Family Physician or Primary Doctor that monitors you? ____

When was the last time you had blood work done? ____