POWER OF LIFE
HOLISTIC HEALTH CENTER
Dr Bryan Ruocco

Dr. Ruocco and his staff would like to **WELCOME** you and **THANK YOU** for choosing our office. Our office is dedicated to helping those who want a "Get to the Root Cause" approach to their overall health and wellness. Our approach is different in that we look to find the cause of your symptoms, rather than treating your symptoms, which will never truly make you well. Dr. Ruocco has been practicing for over 20 years and is committed to helping you understand why you are experiencing your symptoms and the steps that will help you get well and feel your best. Please understand we only accept those cases we truly feel we can help. Please answer the following questions to the best of your ability. Every piece of information is valuable and serves a purpose. This will help us help you. The evaluation we will perform will give us the information needed to determine if you are a good candidate for treatment in our office and whether or not you are in the right place. If we find we can help, we will establish a treatment plan, and explain the steps necessary to getting you well and reaching your goals. We look forward to serving you and helping you achieve greatness in your health journey.

Name: _____ (Age) _____ Gender: M F

Home Address: _____ Best Phone: _____

City, State, Zip: _____ Work Phone: _____

Email Address: _____ Birth Date: _____ / _____ / _____

Marital Status: S M D W Number of Children: _____ SS#: _____

Occupation: _____ Employer Name: _____

How were you referred to this office? _____

To help us best serve you, please answer the following questions to the best of your ability…

Is your visit today a result of a work-related injury, motor vehicle accident or trauma of any kind? YES NO

If yes, please put date and briefly explain: _____

_____

Please tell us the reason for consulting our office…

Primary Complaint (List only one): _____

How long have you had the problem: 1-3wks 1-3 mos. 4-6 mos. 6-12 mos. 1-2 yrs. 3-5yrs 5-10 yrs. > 10-15 yrs. 15+ yrs.

Do you experience any pain, numbness/tingling or pins/needles in any of your extremities? YES NO

If YES, please briefly explain: _____

Do you experience any pain with COUGHING, SNEEZING or with BOWEL MOVEMENTS? YES NO

Please list activities that aggravate your symptoms _____

Please list anything that helps you with your symptoms (exercises, meds, etc.) _____

How would you rate the severity of your symptom? (min) 1 2 3 4 5 6 7 8 9 10 (severe)

Is your condition getting worse? □ No □ Yes, how so? _____

Describe your pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting Stabbing

How often do you experience your symptoms? Constantly Frequently Some of the time On Occasion

What other doctors have you seen for this problem? None Primary MD Orthopedic Neurologist Surgeon Chiropractor

Physical Therapist Massage Therapist Other:_____

List any tests you may have had for this problem: X-Rays MRI Therapy CT Scan Other: _____

Please share how your pain / problem is affecting your life? _____

_____

Other Complaint:_____

How long have you had the problem: 1-3wks 1-3 mos. 4-6 mos. 6-12 mos. 1-2 yrs. 3-5yrs 5-10 yrs. > 10-15 yrs. 15+ yrs.

Please list activities that aggravate your symptoms _____

Please list anything that helps you with your symptoms (exercises, meds, etc.) _____

How would you rate the severity of your symptom? (min) 1 2 3 4 5 6 7 8 9 10 (severe)

Is your condition getting worse? □ No □ Yes, how so? _____

Describe your pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting Stabbing

How often do you experience your symptoms? Constantly Frequently Some of the time On Occasion

What other doctors have you seen for this problem? None Primary MD Orthopedic Neurologist Surgeon Chiropractor

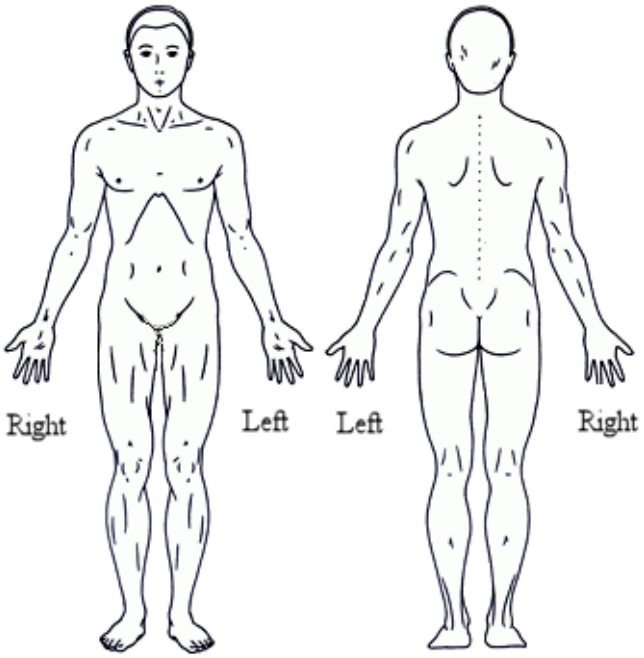
Physical Therapist Massage Therapist Other:_____

List any tests you may have had: X-Rays MRI Therapy CT Scan Other: _____

Please share how your pain / problem is affecting your life? _____

Please list any other health complaints or health challenges:_____

_____



Using the symbols below, mark on the pictures where you have any symptoms...

Numbness = = =

Dull Ache OOO

Burning XXX

Sharp/Stabbing / / /

Pins, Needles + + +

Other _____ ^ ^ ^

Nerve System balance is an important part of a healthy functioning body. Poor nerve system balance can lead to sickness and disease and a host of symptoms as a result. Please mark any of the following symptoms you may be experiencing to help us assess your nerve system balance. If you take medication for any of the following symptoms, please mark the symptom.

	Poor Digestion / Decrease Salvation (dry mouth)		Increased Bowels sounds / Rapid digestion
	Constipation		Hyperactive bowel / Colicky
	Anxiety		Incontinence
	Increased Breathing / Increased Heart Rate		Dizzy / Loss of balance upon standing
	High Blood Pressure		Loves to sleep / Doesn't want to get out of bed in A.M.
	Poor Sleep Quality / Restless		Doesn't Sweat / Decreased Perspiration
	Night Sweats		Increased Libido
	Orgasm Quality Decline		Slow Heart Rate / Low Blood Pressure
	Low Libido (sex drive)		Depression
	Waking Unrested		Increased mucus secretions / Allergies
	Nervousness / Restless / Agitated easily		Increased gag reflex
	Jittery		Diagnosed with an Auto-immune condition
	Increased muscle tension & stress		Afternoon Napper
	Chronic Inflammation / Pain		Slow in the A.M. / Hits the snooze button several times
	Increased susceptibility to colds & infections		Heart Attack / T.I.A.
	Can't shut off brain and relax		Cold Hands / Cold Feet
	Sensitive to Light / Light bothers your eyes		Cancer - Type:
	Migraines / Headaches		Diabetes
			Menstrual Challenges / Hot Flashes / Cramps

Are you a smoker? □ No □ Yes, How many years?_____

Are you under medical care for any condition(s)? No Yes, please list condition(s)_____

_____

Have you ever had any type of surgery? No Yes, please list and include the year it was performed.

_____

Is there a Family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other_____
Father's side	O	O	O	O	O
Mother's side	O	O	O	O	O

EXPERIENCE WITH CHIROPRACTIC

Have you seen or have been seeing a Chiropractor? □ No □ Yes, When? _____

Reason for visiting:_____

How did you respond? □ Well □ Not Well □ Not as Good as I Hoped

Do you take any supplements (i.e. vitamins, minerals, herbs)?

Please list any medication you are currently taking and why?

MEDICATION	REASON FOR MEDICATION
1	
2	
3	
4	

Treatment Goals… We offer many different types of services here in our office, all geared toward improving the health and function of the body as a whole. To be sure we help you the best we can please tell us what your health goals are. (Mark all that apply.)

O I would like to eliminate my pain / symptoms

O I would like to learn why I am experiencing my symptoms

O I would like to improve my eating habits and nutrition

O I would like to improve my energy and well-being

O I would like to improve my hormone health

O I would like to improve my Health and Function

O I would like to improve my posture

O I would like to improve my athletic performance

O I would like to improve my digestive health

O I would like to eat right and lose weight naturally

O other:_____

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

Patient Signature_____ Date_____

CONSENT TO CARE

I do hereby authorize the doctors of Power of LIFE Chiropractic to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays or any other procedure that is advisable, and necessary for my health care. Furthermore, I authorize and agree to allow the Doctor of Chiropractic to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function. I will have an opportunity to discuss with the Doctor of Chiropractic the nature and purpose of chiropractic adjustments and other procedures related to my health care. The Doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.
I authorize the assignment of all insurance benefits be directed to the doctor and/or Power of LIFE, LLC.

I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that any discounted fees I received will be forfeited and all fees incurred will be due and payable at that time.

I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

Signature_____ Date _____
Patient Signature (If under 18, parent signature)

Consent to evaluate and adjust a minor child

I, _____ being the parent of legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive a chiropractic examination, including x-rays, if deemed necessary by the doctor and any care recommended thereafter.

Signature: _____ Date: _____

In Case of Emergency

Name_____ Relationship_____

Work Phone ( ) _____

Home Phone ( ) _____

Cell Phone ( ) _____

Pregnancy Release

This is to certify that I am not pregnant. By signing below the above doctor and his associates have my permission to perform/request an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle:_____

Signature_____ Date:_____

Health Insurance Assignment of Benefits

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to this office. In cases where benefits are not assignable or in any case where your benefit is processed directly to you regardless of assignment, you agree to submit any payments received along with the explanation of benefits to this clinic within 10 days of receipt unless you have paid for the services represented by said payment in full at the time of service. In no case, will an assignment alleviate you of your obligation for payment of services received.

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from Your Clinic Name is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment. In the event, we do accept assignment of benefits we require that you provide a credit card with authorization to bill that account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances, we may require your assistance. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, the balance will be automatically transferred to your credit card or the extended payment plan.

NOTE: Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your insurance program. If you are unsure as to the nature of the service you are receiving, please ask your doctor. For coverage information, it is your responsibility to review your benefit contract.

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The Doctors office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

By signing below, I understand the terms and conditions stated above.

Patient's Signature_____ Date_____/_____/_____

Printed Name: _____

HIPAA-ACKNOWLEDGEMENT OF RECEIPT

Notice of Privacy Practices

We at Power of Life, LLC are required by law to maintain the privacy of and provide individuals with a Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. If you would like a copy of the Notice, please ask.

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

_____ _____

Signature of patient or patient's representative/parent Date

_____ _____

Printed name of patient or patient's representative/parent Relationship to Patient