PATIENT INFORMATION | BRUCE RIZZO DC

6330 Telegraph Avenue
Oakland, CA 94609

510 601-6330(phone)
510 601-6331(fax)

Welcome to our office! Please provide us with the following information for our records.

Date:_________________

Name:____Prefer to be called: ____________________
LAST FIRST MIDDLE

Address:____

City:____ State:__________________ Zip:_______________

Email:_______________________________________

Home Phone: ( ) _________________________ Work Phone: ( ) _________________________

Cell Phone: ( ) _________________________ Fax Number: ( ) _________________________

Which is the best number to contact you or to leave a message? ☐ Home ☐ Work ☐ Cell

Birth Date:__________________________________

Gender: ____________________________________ Pronoun(s): __________________________________

Marital Status: ☐ S ☐ M ☐ P ☐ D ☐ W

Occupation:__________________________________ Employer: ___________________________________

Employer Address/City/State/Zip:____

In Case of Emergency-Contact:____

Relationship:________________________________

Home Phone: ( ) _________________________ Cell/Work Phone: ( ) _________________________

Referred By:____

Physician's Name and Address:____

PATIENT EVALUATION | BRUCE RIZZO DC

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Name:______________________________ Date: ______________

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE. In the space below please describe the present complaint(s) that brought you to this clinic for chiropractic care. The information you provide concerning the past and present symptoms assist your doctor in obtaining an early understanding of your state of health.

1. Present Complaint: ______________________________

2. Please describe the character of your current pain (you may check one or more answers): ☐ Sharp/Stabbing ☐ Sharp/Dull ☐ Aches ☐ Dull
☐ Soreness ☐ Weakness ☐ Throbbing/Gnawing ☐ Numbness ☐ Shooting ☐ Gripping /Constricting ☐ Burning ☐ Tingling

3. How often are the complaints present? ☐ Constant (76-100%) ☐ Frequent (51-75%) ☐ Occasional (26-50%) ☐ Intermittent (25% or less)

4. How bad is your pain or ache? Please check a number: ☐ 0 (NO PAIN) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (UNBEARA BLE)

5. Since your problem began the pain is: ☐ Increasing ☐ Decreasing ☐ Not Changing

6. Did your problem begin: ☐ Immediately after a specific accident ☐ Multiple incidents ☐ Gradually developed over time

7. When did your problem begin? (list specific date if possible): ______________________________

8. Describe how your problem began: ______________________________

9. What treatment have you received for this present condition? ☐ None ☐ Therapy from PT ☐ A back support ☐ Surgery ☐ Spinal injections
Other: ______________________________

10. Were you previously treated for a different occurrence of this same condition? ☐ Yes ☐ No If yes, by: ☐ Chiropractor ☐ MD ☐ Therapy
Other: ______________ Specify dates and type of treatment: ______________________________

11. What makes your problem better? ☐ Nothing ☐ Laying down ☐ Walking ☐ Standing ☐ Movement /Exercise ☐ Inactivity
Other: ______________

12. What makes your problem worse? ☐ Nothing ☐ Laying down ☐ Walking ☐ Standing ☐ Movement /Exercise ☐ Inactivity
Other: ______________

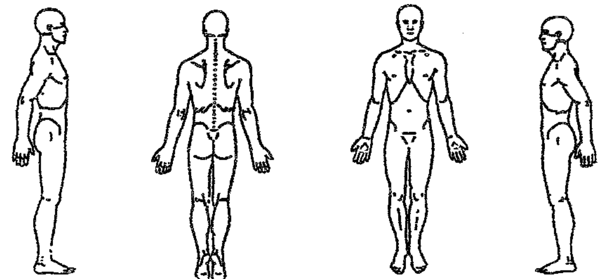
13. How would you grade your stress level? ☐ No Stress ☐ Minimal Stress ☐ Moderate Stress ☐ Greatly Stressed

14. Physical activity at work: ☐ Sedentary (More than 50% of Workday) ☐ Light Manual Labor ☐ Manual Labor ☐ Heavy Manual Labor

15. General physical activity: ☐ No Regular Exercise Program ☐ Light Exercise program ☐ Strenuous Exercise Program

16. Are your complaints affecting your ability to work or otherwise be active? ☐ No effect ☐ Some physical restrictions (able to do light duty tasks)
☐ Need limited assistance with common everyday tasks ☐ Need assistance often ☐ Have a significant inability to function without assistance
☐ Am totally disabled (impaired)/Cannot care for self

Mark an X on the picture where you continue to have symptoms – including pain, numbness, tingling etc.



Do you want further information/or have additional questions regarding:

____

Any suggestions how we can improve our service to you and to others:

____

Patient's Signature:______________________________ Date: ______________

HEALTH HISTORY | BRUCE RIZZO DC

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Name:________________________________ Date:____________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

☐Yes ☐No AIDS/HIV	☐Yes ☐No Diabetes	☐Yes ☐No Measles	☐Yes ☐No Rheumatic Fever
☐Yes ☐No Alcoholism	☐Yes ☐No Emphysema	☐Yes ☐No Migraine Headaches	☐Yes ☐No Scarlet Fever
☐Yes ☐No Allergy Shots	☐Yes ☐No Epilepsy	☐Yes ☐No Miscarriage	☐Yes ☐No Stroke
☐Yes ☐No Anemia	☐Yes ☐No Fractures	☐Yes ☐No Mononucleosis	☐Yes ☐No Suicide Attempt
☐Yes ☐No Anorexia	☐Yes ☐No Glaucoma	☐Yes ☐No Multiple Sclerosis	☐Yes ☐No Thyroid Problems
☐Yes ☐No Appendicitis	☐Yes ☐No Goiter	☐Yes ☐No Mumps	☐Yes ☐No Tonsillitis
☐Yes ☐No Arthritis	☐Yes ☐No Gonorrhea	☐Yes ☐No Osteoporosis	☐Yes ☐No Tuberculosis
☐Yes ☐No Asthma	☐Yes ☐No Gout	☐Yes ☐No Pacemaker	☐Yes ☐No Tumors or Growths
☐Yes ☐No Bleeding Disorder	☐Yes ☐No Heart Disease	☐Yes ☐No Parkinson's Disease	☐Yes ☐No Typhoid Fever
☐Yes ☐No Breast Lump	☐Yes ☐No Hepatitis	☐Yes ☐No Pinched Nerve	☐Yes ☐No Ulcers
☐Yes ☐No Bronchitis	☐Yes ☐No Hernia	☐Yes ☐No Pneumonia	☐Yes ☐No Vaginal Infections
☐Yes ☐No Bulimia	☐Yes ☐No Herniated Disk	☐Yes ☐No Polio	☐Yes ☐No Venereal Disease
☐Yes ☐No Cancer	☐Yes ☐No Herpes	☐Yes ☐No Prostate Problem	☐Yes ☐No Whooping Cough
☐Yes ☐No Cataracts	☐Yes ☐No High Cholesterol	☐Yes ☐No Prosthesis	☐Yes ☐No Other ________
☐Yes ☐No Chemical Dependency	☐Yes ☐No Kidney Disease	☐Yes ☐No Psychiatric Care	____________
☐Yes ☐No Chicken Pox	☐Yes ☐No Liver Disease	☐Yes ☐No Rheumatoid Arthritis	____________

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Packs/Day__________
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week__________
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day__________
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason__________

Are you pregnant? ☐Yes ☐No Due Date ____________

Describe Injuries/Surgeries you have had:		Date:
Falls	______________________________	__________
Head Injuries	______________________________	__________
Broken Bones	______________________________	__________
Dislocations	______________________________	__________
Surgeries	______________________________	__________

FINANCIAL POLICY | BRUCE RIZZO DC

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Welcome to 6330 Telegraph Ave.
The purpose of the following agreement is to help serve you.

PAYMENT OF BILLS

We request that charges be paid in full at the time of service. After your initial office visit, you may pay once at the end of the week if you have multiple appointments in a single week. We will expect you to honor the financial agreements you make with our office. If you find that your circumstances change, advise the doctor/staff immediately so new arrangements can be made. Private insurance companies will not be billed.

MISSING OR CHANGING APPOINTMENTS

If you miss an appointment or cancel with less than 24-hour notice, there will be a missed visit charge.

PROGRESS EVALUATIONS AND RE-EXAMINATIONS

During your treatment series, progress evaluations and check-ups may take place. Depending on the complexity/length of time for these visits, additional fees may apply.

FOR PATIENTS REGARDING PERSONAL INJURY (EXAMPLE: MOTOR VEHICLE INSURANCE)

Please understand that your insurance policy is an agreement between you and your insurance company. You are financially responsible for all services rendered to you in our office. We are willing to bill your auto insurance carrier directly upon proof of available medical-payment coverage. If you miss an appointment or cancel with less than 24-hour notice, you will be charged a full appointment fee. We will not bill insurance companies for missed appointments. You are personally responsible for missed/cancelled visit charges.

I have read the above and I understand and accept these policies.

Name:____ Date: ____________________