

**Dr. Anthony J. DeCosta**  
Family Chiropractor  
129 South Plainfield Avenue  
South Plainfield, NJ 07080

**Phone:** (908) 755-1117  
**FAX:** (908) 755-8273  
stayhealthy@drdecosta.com  
[www.drdecosta.com](http://www.drdecosta.com)

**CONFIDENTIAL CASE HISTORY**  
**ANSWER ALL QUESTIONS – PLEASE PRINT**

**DATE** \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Email \_\_\_\_\_ Sex \_\_\_\_\_

Marital Status \_\_\_\_\_ Children \_\_\_\_\_ S.S. # \_\_\_\_\_

Occupation \_\_\_\_\_ Employer's name \_\_\_\_\_

Address At Work \_\_\_\_\_ Phone \_\_\_\_\_

Who to contact in case of emergency? Name \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Who referred you to this office? \_\_\_\_\_

Do you have Health Insurance? \_\_\_\_\_ Does it cover Chiropractic Care? \_\_\_\_\_ Insurance ID # \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

Do you take any drugs or medication? \_\_\_\_\_  
If so, list \_\_\_\_\_

Have you ever been hospitalized? \_\_\_\_\_  
If yes, what for. \_\_\_\_\_

Have you ever had surgery? \_\_\_\_\_  
If yes, list \_\_\_\_\_

Have you ever had any falls, accidents or injuries? \_\_\_\_\_  
If yes, list \_\_\_\_\_

If you are a female patient, do you have any reason to think you might be pregnant? \_\_\_\_\_  
If so, how far along? \_\_\_\_\_

Have you ever been under Chiropractic care before? \_\_\_\_\_  
Chiropractor's name \_\_\_\_\_ How long under care? \_\_\_\_\_

Give approximate date of last adjustment. \_\_\_\_\_  
State reason for discontinuing care. \_\_\_\_\_

What is your reason for coming to this office? \_\_\_\_\_

Have you seen any other Doctor (M.D., D.O., D.C.) about this? \_\_\_\_\_  
If yes, what was the outcome? \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE**

Comments:

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Please indicate whether you have NEVER, PREVIOUSLY, or are PRESENTLY having the following problems: (Codes) 1 – NEVER 2 – PREVIOUSLY 3- PRESENTLY

**GENERAL SYMPTOMS**

- Headache
- Fever
- Chills
- Night Sweats
- Fainting
- Dizziness
- Convulsions
- Loss of Sleep
- Fatigue
- Nervousness
- Loss of Weight
- Numbness or pain in arms, legs, hands
- Allergy (what)
- Wheezing
- Neuralgia

**GASTRO-INTESTINAL**

- Poor Appetite
- Poor Digestion
- Excessive Hunger
- Belching or Gas
- Nausea
- Vomiting
- Vomiting Blood
- Pain over Stomach
- Constipation
- Diarrhea
- Colon Trouble
- Hemorrhoids (piles)
- Liver Trouble
- Jaundice
- Gall Bladder Trouble

**RESPIRATORY**

- Chronic Cough
- Spitting Blood
- Spitting Phlegm
- Chest Pain
- Difficulty Breathing

**GENITO-URINARY**

- Frequent Urination
- Painful Urination
- Blood in Urine
- Kidney Infection
- Bed Wetting
- Inability to Control Urine
- Prostate Trouble

**EYE EAR NOSE THROAT**

- Poor Vision
- Crossed Eyes
- Pain in Eyes
- Deafness
- Earache
- Ear Noises
- Ear Discharge
- Nasal Obstruction
- Nose Bleeds
- Sore Throat
- Hoarseness
- Hay Fever
- Asthma
- Frequent Colds
- Enlarged Thyroid
- Tonsillitis
- Sinus Trouble

**MUSCLES & JOINTS**

- Weakness
- Twitching
- Stiff Neck
- Backache
- Swollen Joints
- Tremors
- Foot Trouble
- Painful Tail Bone
- Spinal Curvature
- Faulty Posture
- Pain between Shoulders
- Hernia
- Growing Pains

**CARDIO-VASCULAR**

- Rapid Heart
- Slow Heart
- High Blood Pressure
- Low Blood Pressure
- Pain over Heart
- Previous Heart Trouble
- Swelling of Ankles
- Poor Circulation
- Varicose Veins
- Strokes

**SKIN**

- Skin Eruptions
- Itching
- Bruising
- Dryness
- Boils
- Sensitive Skin
- Hives or Allergy
- Eczema

**FOR WOMEN ONLY**

- Painful Periods
- Excessive Flow
- Irregular Cycles
- Hot Flashes
- Cramps or Backache
- Miscarriage
- Vaginal Discharge
- Pregnant at this time

**HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES?**

- |                                  |                                    |                                       |                                             |
|----------------------------------|------------------------------------|---------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Polio   | <input type="checkbox"/> Lumbago   | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Heart Disease      |
| <input type="checkbox"/> Anemia  | <input type="checkbox"/> Eczema    | <input type="checkbox"/> Alcoholism   | <input type="checkbox"/> Scarlet Fever      |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Sciatica  | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Typhoid Fever      |
| <input type="checkbox"/> Mumps   | <input type="checkbox"/> Epilepsy  | <input type="checkbox"/> Chickenpox   | <input type="checkbox"/> Rheumatic Fever    |
| <input type="checkbox"/> Cancer  | <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Pneumonia    | <input type="checkbox"/> Venereal Infection |
| <input type="checkbox"/> Goiter  | <input type="checkbox"/> Pleurisy  | <input type="checkbox"/> Rheumatism   | <input type="checkbox"/> Mental Disorders   |
| <input type="checkbox"/> Flu     | <input type="checkbox"/> Malaria   | <input type="checkbox"/> Diphtheria   | <input type="checkbox"/> Whooping Cough     |
| <input type="checkbox"/> Chorea  | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Arthritis    |                                             |

*I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.*

Signature \_\_\_\_\_

(If patient is a minor, name of parent or guardian)

## TERMS OF ACCEPTANCE AND CONSENT FOR CARE

THIS DOCUMENT CONSTITUTES INFORMED CONSENT FOR CHIROPRACTIC CARE

When a patient seeks Chiropractic health care, and when a chiropractor accepts a patient for such care, it is essential that both are seeking and working towards the same goals.

Chiropractic has only one goal. It is important that the patient understand this goal and the means that will be used to attain it. This will prevent confusion, misunderstanding, or disappointment.

Health is a condition of wholeness in which all of the organs are **functioning 100%** all of the time. (Webster) The purpose of the nervous system is to control and coordinate **all bodily function**. Interference to this master system produces improper function in the body.

A **vertebral subluxation** is a misalignment of one or more vertebrae which alters nerve function. The resulting nerve interference causes a state of **dis-ease** or lack of harmony in the body. This causes a reduction in your body's ability to function properly.

The goal of Chiropractic is to locate, analyze and correct these vertebral subluxations. The Chiropractic method of correction is by specific **adjustments** of the spine. These adjustments are intended to remove vertebral subluxations, thereby allowing the innate healing abilities of the body to work at maximum efficiency.

With a proper nerve supply restored through Chiropractic adjustments, the body can begin the process of repair leading to health. In some patients this happens quickly; in others, more slowly. In some patients the repair and maintenance is complete; in others; only partial.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a Chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will so advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY GOAL IS TO ALLOW THE BODY TO DO ITS JOB.** Our only method is the spinal adjustment of vertebral subluxations.

I, \_\_\_\_\_ have read and fully understand the above statements. I therefore accept Chiropractic care on that basis.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE (PARENT OR GUARDIAN IF PATIENT IS A MINOR)

\_\_\_\_\_  
WITNESS

## **PATIENT PREPARATION INSTRUCTIONS FOR COMPUTERIZED PARASPINAL THERMAL IMAGING (CPTI)**

Please read carefully: It is important that you follow these instructions to insure accurate test results.

1. Please arrive at least 15 minutes before your appointment time.
2. Shower or bathe on the morning of the exam.
3. Do not apply any lotions, creams, ointments or powders to the skin prior to the exam.
4. Do not smoke for at least four hours prior to the exam.
5. Do not consume hot or cold beverages for one hour prior to the exam.
6. Do not consume caffeinated beverages (coffee, tea, soda) for at least four hours prior to exam.
7. Do not consume alcoholic beverages for 24 hours prior to exam.
8. Do not undergo any EMG testing, acupuncture, physical therapy, or use of a TENS for 24 hours prior to the exam.
9. Do not sunbathe or utilize a tanning facility for at least two days prior to the exam. You must be free from sunburn.
10. If you have long hair, please bring a barrette.
11. Please wear loose fitting garments (no tight elastic undergarments or support hose). If possible, female patients are asked to wear a blouse that unbuttons from the back. No jewelry should be worn.
12. If you must cancel, please give at least 24 hours notice!

Appointment Date: \_\_\_\_\_

Appointment Time: \_\_\_\_\_

Thank you for your cooperation.