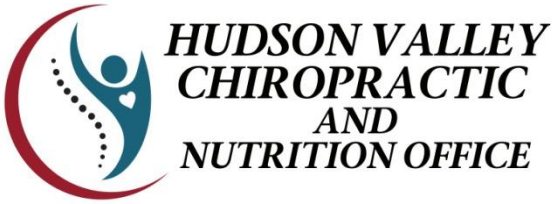


CHIROPRACTIC PATIENT INTAKE FORM

475 Tuckahoe Road Suite 201
Yonkers, NY 10710
Telephone 914-793-1824 Fax 914-793-8654

Disclaimer: Thank you for your interest in being a patient of our office. Information collected about new patients is confidential and will be treated accordingly.

PATIENT DETAILS

Patient Name: _____
Date of Birth: _____
SSN: _____ **Sex**: ☐ Male ☐ Female ☐ Other: _____
Street Address: _____
City: _____ **State**: _____ **ZIP Code**: _____
Home Phone: _____ **Mobile Phone**: _____
Work Phone: _____ **E-Mail**: _____
# of Children: _____ **Marital Status**: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Did anyone refer you:_____
Employer (if any): _____ **Job Title**: _____
Primary Physician: _____ **Phone**: _____
Have you been to a chiropractor before? ☐ Yes ☐ No

- If so, how long ago? _____ Where? _____

Emergency Contact Information

Emergency Contact: _____ **Phone**: _____
Relationship to Patient: _____

INSURANCE POLICIES

Primary Insurance Company: _____
Group #: _____ **ID #**: _____
Policyholder Name: _____ **Date of Birth**: _____
Relationship to Patient: _____

Secondary Insurance Company: _____
Group #: _____ **ID #**: _____
Policyholder Name: _____ **Date of Birth**: _____
Relationship to Patient: _____

SYMPTOMS

Purpose of this appointment:

_____

_____

List the areas on your body where you experience pain:

_____

_____

_____

Describe your symptoms in order of severity, beginning with the worst symptom:

_____

_____

_____

How long ago did your symptoms begin? _____

What caused your symptoms? ☐ Motor Vehicle Accident ☐ Work Accident ☐ Other

- If other, explain: _____
- Major Accidents/Falls?_____

How often do your symptoms occur?

☐ Constantly ☐ Frequently ☐ Occasionally ☐ Intermittently

(76%-100% of the day) (51%-75% of the day) (26%-50% of the day) (0%-25% of the day)

What makes your symptoms better? _____

What makes your symptoms worse? _____

Other doctors seen for this condition? _____

Disabled from work and dates? _____

Are you taking:

☐ Nerve Pills ☐ Pain Killers ☐ Muscle Relaxers ☐ Blood Pressure Medicine

☐ Insulin

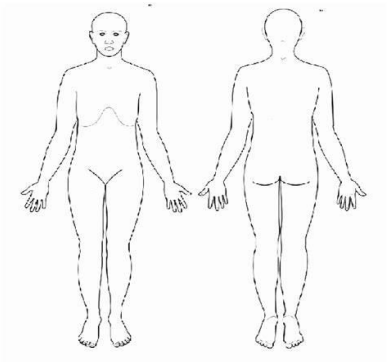
Other Medication:

_____

_____

_____

Please outline on the diagram the area of your discomfort:



PATIENT HEALTH HISTORY

Indicate the medical conditions that you have had:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Epilepsy
- ☐ Eczema/Skin Disorders
- ☐ Goiter
- ☐ Heart Disease
- ☐ Influenza
- ☐ Lumbago
- ☐ Malaria
- ☐ Measles
- ☐ Mental Disorder
- ☐ Mumps
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlett Fever
- ☐ Small Pox
- ☐ Typhoid Fever
- ☐ Tuberculosis
- ☐ Venereal Infection
- ☐ Whooping Cough
- ☐ Other_____

Indicate the surgeries that you have had:

- ☐ Appendectomy
- ☐ Brain
- ☐ Cardiovascular Procedure
- ☐ Carpal Tunnel
- ☐ Cervical Spine
- ☐ Gallbladder
- ☐ Gastrointestinal
- ☐ Hernia
- ☐ Hysterectomy
- ☐ Joint Replacement
- ☐ Knee
- ☐ Lumbar Spine
- ☐ Prostate
- ☐ Shoulder
- ☐ Thoracic Spine
- ☐ Urogenital
- ☐ Other: _____

Musculo-Skeletal Codes:

- ☐ Arm Pain
- ☐ Difficulty Chewing
- ☐ Joint Pain/Stiffness
- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Pain b/w shoulders
- ☐ Walking Problems

Nervous System Codes:

- ☐ Cold/Tingling Extremities
- ☐ Confusion
- ☐ Convulsions
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Forgetfulness
- ☐ Numbness
- ☐ Paralysis

General Codes:

- ☐ Allergies
- ☐ Fever
- ☐ Headache
- ☐ Loss of Sleep

Initial _____ **Date** _____

Gastro-Intestinal Codes:

- ☐ Abdominal Cramps
- ☐ Black/Bloody Stool
- ☐ Colitis
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Gall Bladder
- ☐ Gas/Bloating
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Liver Trouble
- ☐ Vomiting
- ☐ Weight Trouble

Genito-Urinary Codes:

- ☐ Bladder Trouble
- ☐ Discolored Urine
- ☐ Painful/Excessive Urine

C-V-R Codes:

- ☐ Ankle Swelling
- ☐ Blood Pressure
- ☐ Chest Pain
- ☐ Heart Problems
- ☐ Irregular Heartbeat
- ☐ Lung/Congestion
- ☐ Short Breath
- ☐ Varicose Brains

EENT Codes:

- ☐ Dental Problems
- ☐ Earaches
- ☐ Hearing Difficulty
- ☐ Sore Throat
- ☐ Stuffed Nose
- ☐ Vision Problems

Male/Female Codes:

- ☐ Breast Pain/Lumps
- ☐ Genital Herpes
- ☐ Menstrual Cramping
- ☐ Menstrual Irregularity
- ☐ Prostate/Sex Dysfunction
- ☐ Vaginal Pain/Infections

Indicate the allergies that you have:

- ☐ Eggs
- ☐ Fish/Shellfish
- ☐ Milk/Lactose
- ☐ Peanuts
- ☐ Soy
- ☐ Wheat/Gluten
- ☐ Other: _____

☐ None of the above

Do you drink alcohol? ☐ Yes ☐ No

- If yes, how many drinks per week? _____

Do you smoke cigarettes? ☐ Yes ☐ No

- If yes, how many cigarettes per day? _____

Do you chew tobacco? ☐ Yes ☐ No

- If yes, how often? ☐ Frequently ☐ Occasionally ☐ Rarely

Do you drink caffeine? ☐ Yes ☐ No

- If yes, how many cups per day? _____

How often do you exercise? ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

How often do you wear a seatbelt? ☐ Always ☐ Occasionally ☐ Never

Initial _____ **Date** _____

Acknowledgement

By signing below, I hereby acknowledge, agree, and authorize all of the following:

a) **Accurate Information**. I certify that the information provided on this form is accurate, complete, and up to date to the best of my knowledge.

b) **Patient Rights and Responsibilities**. I understand that the healthcare facility maintains a Notice of Privacy Practices, which describes how my protected health information may be used and disclosed, and how I may access my health records.

c) **Release of Medical Information**. I authorize the release of my health information to the healthcare facility in accordance with the healthcare facility's Notice of Privacy Practices. This includes, but is not limited to, releasing medical information to my referring physician, primary care physician, and any physician(s) I may be referred to. The healthcare facility shall ensure all health information remains confidential, as required by HIPAA, and will not release any of my health information without my consent.

d) **Consent for Treatment**. I grant the healthcare facility, including its affiliated providers, physicians, and other medical personnel, permission to use the health information provided for the purpose of my medical treatment as necessary.

e) **Consent to Communication**. I consent to receiving communications from the healthcare facility regarding appointment reminders, test results, and other necessary healthcare-related information via phone, email, or other channels.

f) **Assignment of Benefits.** The undersigned patient (or responsible party) acknowledges and agrees that he/she is financially responsible for all charges for services rendered by the Provider, regardless of insurance coverage. Submission of claims to any insurance carrier is performed and does not relieve the patient of financial responsibility. In the event that any portion of the charges is denied, deemed non-covered, not paid in full by the insurance carrier, or otherwise remains unpaid for any reason, the undersigned agrees to promptly pay all such amounts in accordance with the Provider's standard billing practices. It is the responsibility of the patient to ensure that all necessary referrals, authorizations, and coverage's are in place prior to receiving services.

g) **Acknowledgment**. By signing below, I hereby acknowledge, agree, and authorize all of the above, and I authorize the healthcare facility to retrieve and review my medical history and authorize the healthcare facility to release the information required in obtaining procedure authorization or the processing of any insurance claims.

Patient Signature: _____ **Date**: _____

Print Name: _____

Parent or Guardian Signature: _____ **Date**: _____

Print Name: _____