# Abrankian Back & Neck Center

43-48 48th Street Sunnyside, NY 11104-1602
Phone: (718) 472-0448  Fax: (718) 472-9555
www.SunnysideSpine.com


Dear New Patient:

Welcome to the office !

In order to save time spent in our office on your first visit, please find enclosed a copy of our "New Patient" packet. We ask that you kindly complete the forms in the packet in their entirety.

Please fill out forms enclosed and print , bring with you on your appointment.

Preparation for your upcoming consultation in our office:

1. Please bring with you previous spinal X-ray or MRI reports if available
2. Wear comfortable loose clothing ( sweat pants)
3. Wear a face mask , only patient are allowed in the office due to Covid restrictions
4. Overall plan on being in our office approximately  45min to 1 hr.

If you have any further questions, please feel free to contact our office at (718) 472-0448 or email us  SunnysideSpine@gmail.com

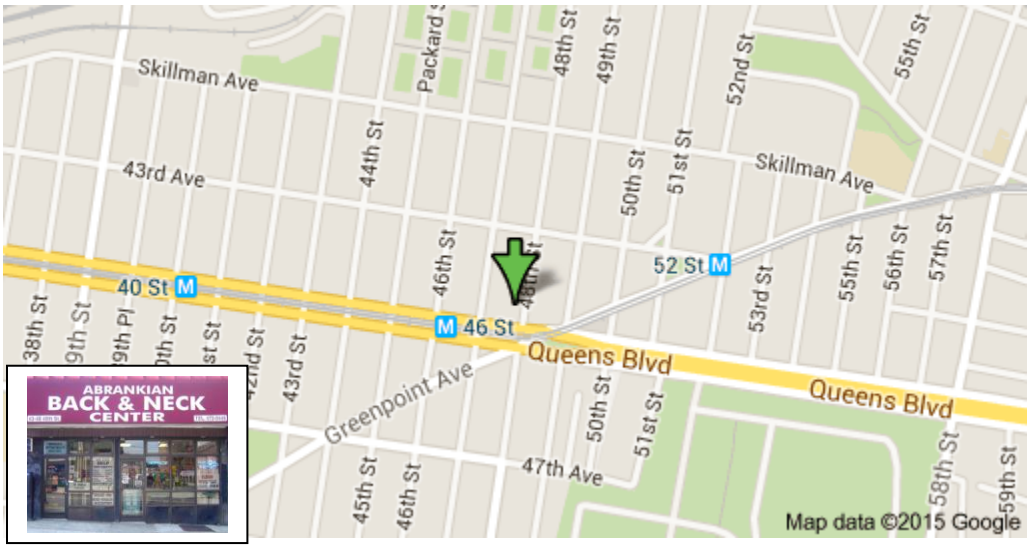
We look forward to seeing you at your scheduled appointment.

Please Note :Our office policy is 24 hr cancellation notice

Sincerely,

Taline
Patient Coordinator

## DIRECTIONS TO OUR OFFICE




**Abrankian Back & Neck Center**
**43-48 48th St.**
**Sunnyside, NY 11104**

Our office is located at 48th St. between 43rd Ave. and Queens Blvd. We are on the corner of 48St. and Queens Blvd.

**Driving:**
From Forest Hills, continue on Queens Blvd. going towards Manhattan and make a right at 48th St.

From Manhattan, get on NY-25 E/Ed Koch Queensboro Bridge from E 59th St. Follow NY-25 E to 43rd St in Queens. Follow 43rd St to 48th St. Turn left onto 43rd St. Turn right at the 2nd cross street onto 43rd Ave. Turn right onto 48th St.

**Mass Transit:**
Buses: Take Q104, Q32 or Q60 to Queens Blvd & 48th St.
Train: Take the "7" to 46th St/Bliss. Continue on Queens Blvd towards 48th St. Make a left a 48th St.

If you have any questions, you can call us at (718) 472-0448.

# *Welcome To The Abrankian Back & Neck Center*

## *PATIENT INFORMATION* ( Please Print )

FIRST NAME_____ LAST NAME _____ DATE_____

ADDRESS_____ APT. #_____ CITY_____ ZIP_____

PHONE_____ DATE OF BIRTH_____

E-MAIL ADDRESS:_____

CELL PHONE #:_____ CELL CARRIER: ☐ VERIZON ☐ AT&T ☐ T-MOBILE ☐ SPRINT OTHER_____

MARITAL STATUS: ☐ M ☐ S ☐ D ☐ W SEX: M ☐ F ☐ AGE:_____ # OF CHILDREN_____

OCCUPATION_____EMPLOYER_____

HOW DID YOU HEAR ABOUT THIS OFFICE? _____

## PATIENT CONDITION:

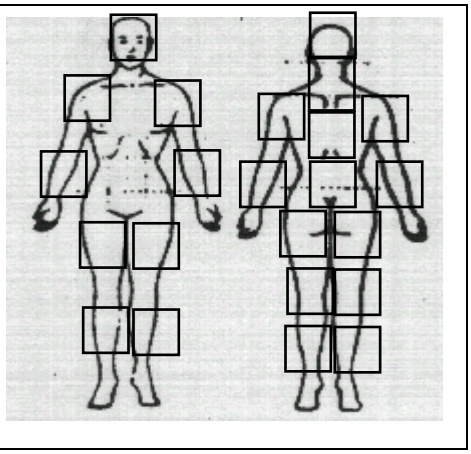
**HAVE YOU HAD CHIROPRACTIC CARE BEFORE?** ☐ YES ☐ NO WHEN? _____ DR. NAME: _____

**DESCRIBE YOUR SYMPTOMS**:_____ HOW LONG?_____

**IS THIS CONDITION GETTING PROGRESSIVELY WORSE?** ☐ YES ☐ NO ☐ UNKNOWN

**ARE YOU TAKING MEDICATIONS ?** ☐ NO ☐ YES, (LIST):_____

**MARK AN (X) ON THE PICTURE WHERE YOU HAVE PAIN:**



**TYPE OF PAIN** ☐ SHARP ☐ DULL ☐ THROBBING ☐ ACHING
☐ STIFFNESS ☐ TINGLING ☐ NUMBNESS ☐ SHOOTING
☐ OTHER:_____

**HOW OFTEN DO YOU EXPERIENCE YOUR SYMPTOMS ?**
☐ Constantly ( 76-100% of day ) ☐ Frequently ( 51-75% of day)
☐ Occasionally (26-50% of day ) ☐ Intermittently ( 0-25% of day)

**CIRCLE HOW BAD ARE YOUR SYMPTOMS FROM 0 -10:**
0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐
(NO PAIN) - - -(MODERATE)- - -(SEVERE PAIN)

**WHAT ACTIVITIES MAKE YOUR SYMPTOMS *WORSE:***
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lifting ☐ Lying Down ☐ Other: _____

**WHAT ACTIVITIES MAKE YOUR SYMPTOMS *BETTER*:**
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lifting ☐ Lying Down ☐ Other: _____

**DOES YOUR SYMPTOMS INTERFERE WITH YOUR?** ☐ WORK ☐ SLEEP ☐ DAILY ROUTINE ☐ RECREATION

**HAVE YOU HAD SIMILAR SYMPTOMS IN THE PAST?** ☐ No ☐ Yes Explain:_____

***WOMEN:*** I have been advised that if I am pregnant and have x-rays taken which may expose my lower torso to radiation, it is possible to injure the fetus. I have been advised that the 10 days following onset of a menstrual period are generally considered to be safe for X-ray examinations. With those factors in mind, I am advising my doctor that:

| | YES | NO | Don't Know |
|---|---|---|---|
| I am pregnant. | ☐ | ☐ | ☐ |
| I am late with my menstrual period. | ☐ | ☐ | ☐ |
| I am taking oral contraceptives. | ☐ | ☐ | ☐ |
| I have an IUD. | ☐ | ☐ | ☐ |
| I have had a tubal ligation. | ☐ | ☐ | ☐ |
| I have had hysterectomy. | ☐ | ☐ | ☐ |

***HEALTH HISTORY*** ***( Have you ever suffered from any of these? Please ✓ below)***

☐Aids/HIV ☐Anemia ☐Arthritis ☐Asthma ☐Bleeding Disorders ☐Breast Lumps ☐Cancer ☐Diabetes ☐Epilepsy

☐Gout ☐Heart Disease ☐Kidney Disease ☐Dizziness ☐Digestive Disorders ☐Headaches ☐High Blood Press ☐ Osteoporosis

☐ Pace Maker ☐Prostate Problems ☐Stroke ☐Tumors ☐ Other:_____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____ _____ _____

## 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 ☐Thyroid Disease ☐Osteoporosis ☐Scoliosis ☐ Disc condition ☐ Back condition

# IMPACT OF YOUR SYMPTOMS

**How much have your symptoms interfered with your daily activities?

☐Not at all ☐A little bit ☐Moderately ☐Quite a bit ☐Extremely

**WORK ACTIVITY INCLUDE:** ☐Sitting ☐Standing ☐ Light Labor ☐Heavy Labor

**EXERCISE:** ☐None ☐Light ☐Moderate ☐Daily ☐Heavy

**How is this symptom / condition interfering with your life? (check where appropriate)**

| | No Effect | Mild Effect | Moderate Effect | Severe Effect | | No Effect | Mild Effect | Moderate Effect | Severe Effect |
|---|---|---|---|---|---|---|---|---|---|
| Work | ☐ | ☐ | ☐ | ☐ | Energy | ☐ | ☐ | ☐ | ☐ |
| Exercise | ☐ | ☐ | ☐ | ☐ | Attitude | ☐ | ☐ | ☐ | ☐ |
| Recreation | ☐ | ☐ | ☐ | ☐ | Patience | ☐ | ☐ | ☐ | ☐ |
| Relationships | ☐ | ☐ | ☐ | ☐ | Productivity | ☐ | ☐ | ☐ | ☐ |
| Sleep | ☐ | ☐ | ☐ | ☐ | Creativity | ☐ | ☐ | ☐ | ☐ |
| Self-Care | ☐ | ☐ | ☐ | ☐ | Other: _____ | ☐ | ☐ | ☐ | ☐ |

# PATIENT WELLNESS ASSESSMENT

Do you drink alcohol? ☐ Yes ☐ No - How much and how often? _____

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


On the arrow diagram above:

E. What number do you think represents your health today?_____

F. In what direction is your health currently headed ?_____

G. What are your health goals?

IMMEDIATE:_____

_

SHORT TERM _____

LONG TERM_____

How committed are you to correcting this issue? ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

Not committed — Very committed

**In general, would you say your overall health right now is…

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

**Do you take vitamins? ☐ Yes ☐ No _____**

**When was the last time you had blood work done? _____**

**Height: _____ Weight: _____ lbs. Name of Primary Care Physician: _____**

**DO YOU HAVE HEALTH INSURANCE?** ☐ Yes ☐ No *IF YES:* ***Please print below & Give us a copy of the card.***

Name of Insurance Company(s)_____

GROUP#_____ MEMBER ID#_____

**ASSIGNMENT OF BENEFITS AND POWER OF ATTORNEY TO CASH CHECKS**

I, the undersigned, do hereby authorize payment directly to the office above, the benefits of my coverage, if any, otherwise payable to me for services but not to exceed the customary charge for those services. I understand that I am financially responsible for all charges whether or not paid by insurance. If these payments are made out to me I grant unto the office below as attorney the full power and authority in my name and stead to endorse any and all checks and drafts or money orders. I hereby authorize the doctor to release all information necessary to secure payment of benefits. A photocopy of this assignment shall be valid.

**Signature:_____ Date:_____**