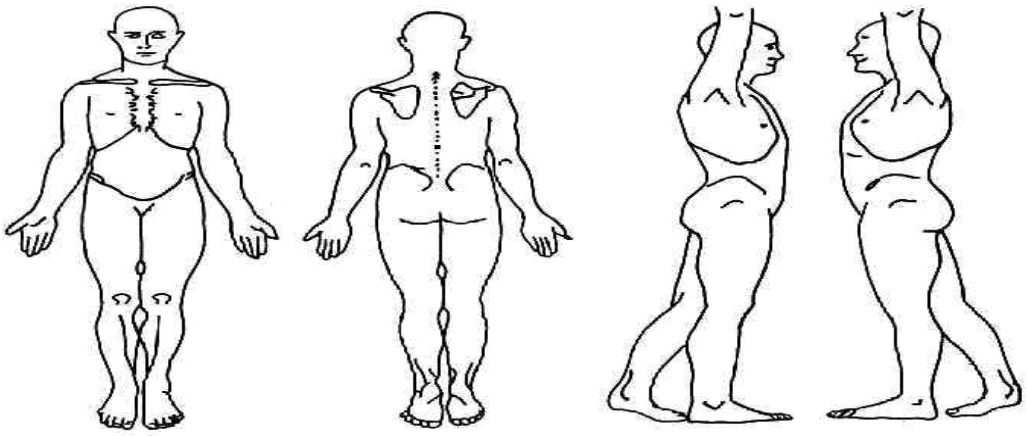
PATIENT INTAKE FORM

Patient Name: _____ Date:_____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation Other: _____

2. Indicate (circle or X) on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

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

8. How much has the problem interfered with your social activities?

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

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? _____

11. How do you think your problem began? _____

12. What aggravates your problem? _____

13. What alleviates your problem? (makes it feel better) _____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height _____ **Weight** _____ **Date of Birth** _____
Occupation _____

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Strenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependence
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite		**For Females Only**
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other: _____				

20. List all prescription and/or over-the-counter medications you are currently taking:
_____

21. List all surgical procedures you have had:
_____

22. What activities do you do at work?
□ **Sit:** □ Most of the day □ Half the day □ A little of the day
□ **Stand:** □ Most of the day □ Half the day □ A little of the day
□ **Computer work:** □ Most of the day □ Half the day □ A little of the day
□ **On the phone:** □ Most of the day □ Half the day □ A little of the day

23. What activities do you do outside of work?
_____

24. Have you ever been hospitalized? □ No □ Yes
If yes, why: _____

25. Have you had significant past trauma? □ No □ Yes

26. Anything else pertinent to your visit today? _____

27. Do you have neck, back or shoulder pain related to breast size? □ No □ Yes
If yes, for how long? : □ 0-3 months □ 3-12 months □ 12 + months

Patient Signature: _____ **Date:** _____

Patient's Pregnancy Evaluation Form

In order for us to fully evaluate you, we are required to take X-rays of some part of your body. It has been found that an unborn child in its first trimester would be more sensitive to radiation that an adult. In order to insure safety, no Fetus (unborn child) be exposed to radiation from X-ray machines. We ask you to provide us with the following information. This information is strictly confidential and solely used for the purpose it is intended. Thank you for your cooperation.

Name: _____

Date of the onset of Last Menstrual Period: _____

Is there a chance you may be pregnant? YES / NO

To the best of my knowledge, I am not pregnant and by providing this application form, Physician/Technologist has informed me of the effects of radiation to the unborn baby and me, by signing below have consented to taking the X-ray of my body part, pertinent for evaluation and further studies.

_____ _____

Dated Signature

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____ have received/read a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third party payers.
- Conduct normal health care operations such as quality assessment and accreditation.

_____ _____

Signature of Patient,
Parent or Legal Guardian

Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ○ Individual refused to sign
- ○ Communications barriers prohibited obtaining the Acknowledgment
- ○ An emergency situation prevented us from obtaining Acknowledgment
- ○ Other (specify) _____
  _____

_____ _____

Staff Signature Date

Assignment/Direct Payment to Doctor
Private/Group Accident and Health Insurance

I hereby instruct and direct my insurance company to pay the following provider direct payment for services rendered:

30 Broad, Suite 2005
New York, NY 10004

If policy provisions prohibit direct payment to my physician, I hereby request payment for services rendered per current policy provisions. Payment is for the profession or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward charges for profession services rendered.

THIS IS DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THE POLICY.

This payment will not exceed any indebtedness to the above mentioned assignee and have agreed to pay, in current manner, any balance of said professional services charges over and above this insurance payment. A photocopy of this Assignment of Rights and Benefits shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

_____ _____

Dated Signature of Policy Holder

Attention Empire, Oxford, Magnacare, BC/BS and GHI Patients,

Please be aware that **YOU** will be receiving payment directly from your insurance carrier.

It is **YOUR RESPONSIBILITY** to provide us with all checks and associated paperwork.

NOTHING WILL BE CHARGED TO YOUR CREDIT CARD UNLESS YOU FAIL TO BRING IN PAYMENTS IN A TIMELY FASHION.

If you fail to bring in payments for services rendered at this office you will be charged for the entire amount.

Thank you for your cooperation

Name (as it appears on card)_____

Card Number_____

Exp Date_____

3 Digit cvv/cvc code_____

Billing Address_____

City/State/Zip_____

Signature_____

Cancellation Policy/ No Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment book.

If an appointment is not cancelled at least 24 hours in advance, you will be charged a $25 fee. This fee will not be covered by your insurance company.

Print name Signature Date