energy chiropractic

853 Broadway Suite 1601 New York NY 10003 • 212.777.3301 • www.energychironyc.com

ENERGY CHIROPRACTIC PATIENT INTAKE FORM

Last: _____ **First:** _____ **MI:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Cell #: _____ Text Reminders ? ___ yes ___ No **If yes, what carrier?** _____

Home #: _____

Work #: _____ **Ext.:** _____ **Email:** _____

Date of Birth: _____ **Age:** _____ **Social Security #:** _____

Sex: _____M _____F **Relationship status:** _____Single _____Married _____Partnered

Emergency Contact: _____ **Tel. #:**_____

Primary Care Physician: _____ **Tel. #:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Would you like a report detailing your treatment sent to your primary care physician? ___ Yes ___ No

Employer: _____ **Occupation:** _____

Referred by: _____

SYMPTOMS

Reason for visit? _____

When did you first notice the symptoms? _____

How did the symptoms begin? _____

Type of pain you are feeling: ___ Numbness ___ Aching ___ Shooting ___ Burning
___ Tingling ___ Dull ___ Stiffness ___ Swelling
___ Cramps ___ Sharp ___ Throbbing ___ Other _____

Rate the severity of your pain (1-Mild to 10-Severe): 1 2 3 4 5 6 7 8 9 10

Is this condition getting progressively worse? ___ Yes ___ No

Is the pain constant ___ or does it come and go ___?

Do you have a fever? ___ Yes ___ No Have you experienced sudden weight loss? ___ Yes ___ No

Which activities are difficult to perform: ___ Sitting ___ Standing ___ Walking ___ Bending ___ Lying Down
____Other _____

What treatment have you already received for this condition?

__Chiropractic __Medication __Surgery __ Physical Therapy

Name and address of other doctor(s) who have treated you for this condition: _____

_____

Have you had the same/similar condition in the past? (Please describe): _____

_____

HEALTH HISTORY (check all that apply)

___ Acid Reflux
___ AIDS/HIV
___ Alcoholism
___ Allergies
___ Anemia
___ Anorexia / Bulimia
___ Arthritis
___ Asthma
___ Bleeding Disorders
___ Breast Lumps
___ Cancer
___ Chemical Dependency
___ Chicken Pox
___ Depression
___ Diabetes
___ Digestive Disorders
___ Fractures
___ Gout
___ Glaucoma
___ Headache
___ Heart Disease
___ Hemorrhoids
___ Hepatitis
___ Hernia
___ Herniated Disc
___ High Cholesterol
___ High Blood Pressure
___ Joint Pain
___ Kidney Stones
___ Kidney Disease
___ Liver Disease
___ Menstrual Problems
___ Multiple Sclerosis
___ Neurological Disorders
___ Osteoporosis
___ Pacemaker
___ Pinched Nerve
___ Pneumonia
___ Prosthesis
___ Psychiatric Care
___ Sinus Issues
___ Stroke
___ Thyroid Disorders
___ Tuberculosis
___ TMJ
___ Tumors, Growths
___ Ulcers
___ Venereal Disease

Other(s)_____

Date of last physical exam:_____ Allergies: _____

List any types of surgeries and/or accidents which you have had and the dates they occurred:

_____

Please list all medications you are taking: _____

Women:

Are you pregnant? __Yes __No Nursing? ___Yes ___No Taking birth control pills? ___Yes ___No

Family health history: _____

DAILY HABITS

What types of exercise do you perform and how often? _____

What do your daily work habits include? (i.e. sitting, standing, heavy labor, computer work):

_____

What vitamins and nutritional supplements do you take? _____

Do you smoke and if so, how much per day? _____

How much liquor do you consume on a weekly basis? _____

How much coffee, or caffeinated beverages do you consume on a daily basis?_____

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Energy Chiropractic to release my information including the diagnosis and the records of any treatment or examination rendered to me, or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractors insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf, or that of my dependents. I also understand there is a 24 hr. cancellation policy and I am fully responsible to pay for the visit in full if I miss my scheduled visit without a 24 hr. notice.

SIGNATURE OF PATIENT (OR PARENT IF A MINOR) DATE

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for **Energy Chiropractic**, to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (**Energy Chiropractic** Notice of Privacy Practices provides a more complete description of such uses and disclosures).

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Energy Chiropractic** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained in person, or by forwarding a written request to **Energy Chiropractic**, Privacy Officer at 853 Broadway, Suite 1601, New York, NY, 10003.

With this consent **Energy Chiropractic** may call my home or alternative location and leave a message on voice mail, or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care. (Please indicate on your patient information form your contact preferences and restrictions).

With this consent **Energy Chiropractic** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment cards and patient statements. (Please indicate on your patient information form your contact preferences and restrictions).

With this consent **Energy Chiropractic** may email to my home or alternative location any items that assist the practice in carrying out TPO, such as appointment cards and patient statements. (Please indicate on your patient information form your contact preferences and restrictions).

I have a right to request that **Energy Chiropractic** restrict how it uses or discloses my PHI to carry out TPO. By signing this form, I am consenting to **Energy Chiropractic** use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____ _____

Signature of Patient (Or Representative) Date

_____ _____

Printed Name of Patient (Or Representative) Relationship to the Patient