

WELCOME

150 Broadway #1115
New York, NY 10038
P: 212-227-3350

Office Hours

M-W-F: 11 to 2:30 , 4 to 8pm
Thursday: 3-8pm

PATIENT INFORMATION

Date: _____

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Phone #:

(H) _____ (M) _____ (W) _____

Can we call you at work? Yes No

Date of Birth: _____ (mm/dd/yyyy)

Sex: Male Female

Social Security #: _____

Marital Status:

Single Married Divorced Widowed Separated Minor

Occupation: _____ Employer: _____

Employer Address: _____ Phone #: _____

Person to be notified in the case of an emergency:

Name: _____ Relation: _____ Phone #: _____

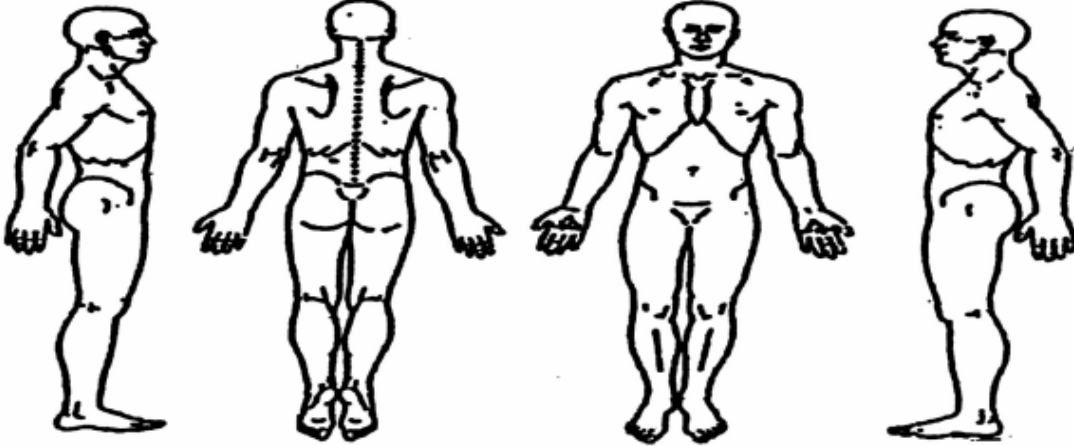
How did you hear about our practice? _____

PATIENT INTAKE FORM

1. What is your chief complaint?

2. Is today's problem caused by: Auto Accident Injury at work Other

3. Indicate on the drawings below where you have pain/symptoms



4. How often do you experience your symptoms?

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

5. How would you describe the type of pain?

- Sharp Burning Tingly
 Dull Shooting Sharp with motion
 Diffuse Stiff Shooting with motion
 Achy Numb Other: _____

6. How are your symptoms changing with time?

- Getting Worse Staying the Same Getting Better

7. 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)

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

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

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

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

10. Who else have you seen for your problem?

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

11. How long have you had this problem?

__ Day(s) __ Week(s) __ Month(s) __ Year(s)

12. How do you think your problem began?

13. Do you consider this problem to be severe?

- Yes Yes, at times No

14. What aggravates your problem?

15. What have you tried to alleviate your problems?

16. What is your:

Height _____ (ft/inch) **Weight** _____ (lbs) **Age** _____

17. How would you rate your overall Health?

- Excellent Very Good Good Fair Poor

18. What type of exercise do you do?

- Strenuous Moderate Light None

19. Indicate if you have any immediate family members with any of the following:

- Rheumatoid Arthritis Diabetes Other
 Heart Problems Cancer

20. 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
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss		
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Asthma
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis		
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder		
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue	<input type="checkbox"/>	For Females Only
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
					<input type="checkbox"/> Pregnancy

21. What is your daily intake of the following?

- Caffeine ___ cups/day Alcohol ___ drinks/wk Cigarettes ___ packs/day

22. List all prescription medications you are currently taking:

23. List all of the over-the-counter medications you are currently taking:

24. List all surgical procedures you have had:

25. What activities do you do at work?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Sit: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |

26. What activities do you do outside of work?

27. Have you ever been hospitalized? No Yes

If yes, why

28. Have you had significant past trauma? No Yes

If yes, please explain

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

- | | |
|---|---|
| <input type="checkbox"/> It could be serious | <input type="checkbox"/> It is affecting golf |
| <input type="checkbox"/> It isn't going away | <input type="checkbox"/> It is affecting sleep |
| <input type="checkbox"/> It is affecting leisure activities | <input type="checkbox"/> It is affecting mental outlook |
| <input type="checkbox"/> It is affecting work | <input type="checkbox"/> It is affecting relationships |
| <input type="checkbox"/> It is getting worse | <input type="checkbox"/> Other: _____ |

30. Anything else pertinent to your visit today? _____

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

Patient Signature _____

Date: _____

NOTE: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our office.

NEUROLOGICAL/VASCULAR QUESTIONNAIRE

1. Do you suffer from neck pain with pain in your shoulders, arms or hands? NO YES
Comment: _____
2. Do you have weakness, numbness, tingling or burning in your shoulders, arms or hands? NO YES
Comment: _____
3. Do your arms or hands fall asleep regularly? NO YES
Comment: _____
4. Do you have reduced feeling (sensation) or swelling in your arms or hands? NO YES
Comment: _____
5. Do you suffer from a loss of handgrip strength? NO YES
Comment: _____
6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
Comment: _____
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
Comment: _____
8. Do you your legs or feet fall asleep regularly? NO YES
Comment: _____
9. Do you have reduced feeling (sensation) or swelling in your legs or feet? NO YES
Comment: _____
10. Do you suffer from cold hands or feet? NO YES
Comment: _____
11. Have you tried any medications such as anti-inflammatory? NO YES
If yes, what kind of medication? _____
12. Have you tried any Physical Therapy before? NO YES
If yes, when? For how long? What kind?

13. Have you tried any Chiropractic treatments before? NO YES
If yes, when? For how long? What kind?

14. Have you had an MRI? NO YES
If yes, when? Who ordered it? What was it ordered for?

15. Have you had X-rays? NO YES
If yes, when? Who ordered it? What was it ordered for?

16. Have you used any splint or braces or other prescribed treatments by an M.D.? NO YES
If yes, when? What kind? Who ordered it?

Insurance/Financial Information

Name of person responsible for this account: _____

Relationship to patient (if other than self): _____ Phone #: _____

Credit/Debit Card Information: (print legibly)

Name of card holder: _____

Credit Card #: _____ Card Type: _____

Expiration Date: _____ CVV Code (3 or 4 digit #): _____

Do you have health insurance? No Yes

Name of Carrier: _____

Name of Policy Holder: _____ Date of Birth of policy holder: _____

If your spouse carries the health insurance, what is their social security #? _____

Do you have a Secondary Insurance? No Yes

Name of Carrier: _____

Name of Policy Holder: _____ Date of Birth of policy holder: _____

If your spouse carries the health insurance, what is their social security #? _____

It is the sole responsibility of the patient to inform us of any and all insurance plans and/or changes; insurance policies are an arrangement between the insurance carrier and the patient. It is the patient's responsibility to make sure that their insurance policy is effective & inform us of which is primary and which is secondary!

Are you enrolled in a section 125? No Yes

(HSA) Health Savings Account

(FSA) Flex Spending Account

(HRA) Health Reimbursement Account

Please provide this office with a copy of your insurance card (s) and driver license.

Assignment and Release (insured patients)

I, certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICAL/MEDICAL PRACTICE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorized the doctor to release all information necessary, including diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

Patient Policies:

Setting the groundwork for positive Doctor-Patient relations:

The purpose of these agreements is to allow us to completely serve you and to get the best results in the shortest amount of time. It is our experience that those patients who adhere to the following agreements get the best results.

Sign-In Policy

When you arrive, please sign in; you will be called in the order in which you have signed in.

Office Hours Policy

Your doctor has specific office hours; the receptionist will schedule your appointment accordingly. Our general office hours are:

Upsets:

We are here to serve you; please speak with your doctor about any upsetting matter. We see your comments as helping us to help you.

Financial Office Policies

- ❖ **Any checks sent to you by the insurance company should be brought to our office within 7 days even if they are payable under your name or your spouses name (in this case, please sign the check). Also, bring the attached insurance payment stub or explanation of charges to record which services were paid.**
- ❖ **Do not cash any checks from the insurance company for services rendered here. If you cash any insurance checks your account will be referred to the collection department of our attorney, Kirschenbaum & Kirschenbaum. If your account should go to collections for any reason, it will be the patient's responsibility for any court costs, attorney's fees and or collection costs incurred in collecting the account balance, typically 30+% of the initial bill.**
- ❖ Your insurance will be verified promptly and will be reviewed with you if applicable; all patients are on a cash basis until our staff can verify all insurance coverage(s). After the verification of your coverage and deductibles, this office may accept assignment on most policies provided the insured/patient signs and appropriate statement of benefits and/or a lien authorizing payment to be sent to the doctor.
- ❖ Any medical or other records or information necessary to process any claims will be released from our office.
- ❖ This office accepts Master Card, Visa, American Express, Discover Card, personal checks, cash & Clear Gage for payment plans.
- ❖ If you have any questions concerning this or any other matter, please speak with the new patient coordinator or our financial department prior to seeing the doctor.

Missing or Changing Appointments Policies:

It is our wish that each and every one of our patients receive the very best care and service possible. Your treatment program consists of a specific series of treatment given over a pre-planned time span. If you don't follow the plan, then you will not receive the desired results. If we did not insist that you meet all your appointments, we would be doing you a disservice and it would be indicative that we did not care. We do care about you and the success of your program here. Therefore, we have a few simple rules that we insist you follow:

- ❖ Meet all your appointments. Arrange the activities in your life so that this can occur.
- ❖ If you are unable to make your appointment due to an emergency, please call us and let us know so we can reschedule your appointment. If you need to change the time of your appointment, plan to come another time on the same day. If the same day is not possible, be sure to make up the missed appointment within one week.
- ❖ With the exception of an unexpected emergency, we require that you notify us 6 hours in advance as to any appointment changes to avoid being charged.
- ❖ For no call/no show appointments or cancellations less than 6 hours in advance, there is a **non-refundable \$50.00 service charge** that will be billed to your credit card/debit card on file.

By signing below you affirm that you have read, understand and agree to follow the above policies.

Patient Signature: _____

Date: _____

Consent to Care

A patient coming to the doctor gives his/her permission and authority to care for them in accordance with the appropriate tests, diagnosis and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not provide specific healthcare if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through healthcare procedures from whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the physician. I affirm that I am not an agent or representative of any insurance company or any other business trying to collect information. All injuries/problems mentioned are true and I am here solely for the treatment of the said problem.

I have read and understand the consent to care.

Signature: _____

Date: _____

