

PERSONAL HISTORY

Name : _____ Address: _____
 City: _____ State: _____ Zip Code: _____
 Home/Cell Phone: _____ Birth Date: _____ Age: _____ Sex: M F
 Social Security# _____ Circle one: Married Single Divorced Widowed
 Business Employer: _____ Type of work: _____
 Business Number: _____ Personal Email: _____
 Referred To This Office By: _____
 Name and Number of Emergency Contact: _____
 Who is Responsible For Your Bill, You and Spouse Workers Comp Auto Insurance Medicare
 Personal Health Insurance (Name) _____ ID # _____

CURRENT HEALTH CONDITION

Purpose of This Appointment _____
 Other Doctors Seen For This Condition: Yes No Who? _____
 Type of Treatment: _____ Results: _____
 When Did This Condition Begin? _____ Has This Condition Occurred Before? Yes No
 Is Condition: Job Related Auto Injury Home Injury Fall Other: _____
 Date of Accident: _____ Time of Accident: _____
 Have You Made A Report of Your Accident To Your Employer: Yes No
 Drugs You Now Take: Pain Killers/Muscle Relaxers Blood Pressure Med. Diabetic Meds Insulin
 Others _____
 Do You Suffer From Any Condition Other Than That Which You Are Consulting Us?

PAST HEALTH HISTORY

Major Surgery/Operations and Dates: _____
 Major Accidents or Falls and Dates: _____
 Hospitalization (Other Than Above): _____
 Previous Chiropractic Care: None Doctor's Name & Approximate Date of Last Visit: _____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | |
|--|--|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema |

INTAKE

- Coffee
- Tea
- Alcohol
- Cigarettes
- White Sugar

Have you been tested HIV positive? Yes No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness

- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

GENITO-URINARY CODE

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

NERVOUS SYSTEM CODE

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

C-V-R CODE

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

GENERAL CODE

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

EENT CODE

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

GASTRO-INTESTINAL CODE

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

MALE/FEMALE CODE

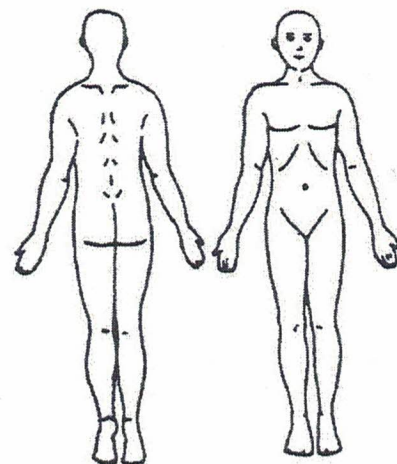
- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems
- _____
- _____
- _____

FEMALES ONLY:

When was your last period? _____

Are you pregnant?

- Yes No Not Sure



Please outline on the diagram the area of your discomfort.

FAMILY HISTORY

The following members have a same or similar problem as I do:

- Mother
- Father
- Brother
- Sister
- Spouse
- Child

DO NOT WRITE BELOW THIS LINE

CHIROPRACTIC ANALYSIS:

DIAGNOSIS:

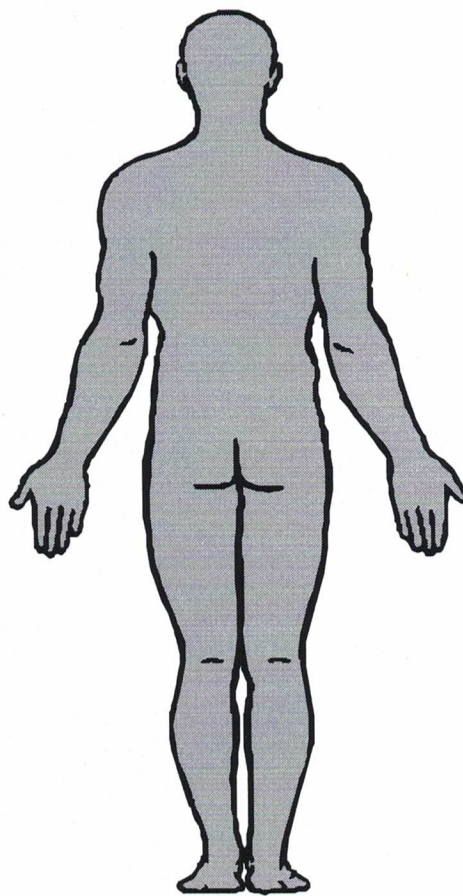
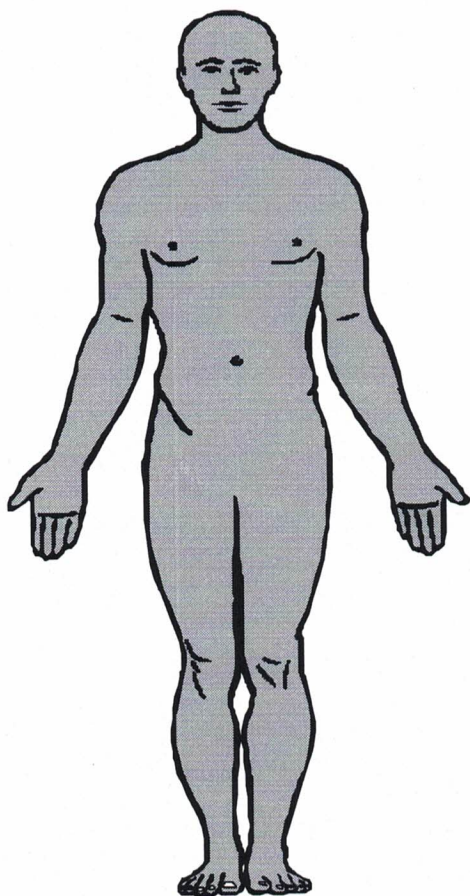
Patient Accepted: Yes No Referred

Doctor's Signature

Name: _____

Date: _____

Pain Scale



0 1 2 3 4 5 6 7 8 9 10

No Pain

Extreme

Please circle areas on the body above where you are feeling pain or discomfort.

Quality of pain: (ex: Burning, Sharp, etc.) _____

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal: to eliminate misalignments within the spinal column, which interfere with the expression of the body's innate wisdom. It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.**

Patient Signature: _____ Date: _____

I, understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged to me and I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered to me will be immediately due and payable, I hereby, authorize the Doctor to treat my condition as he deems appropriate through use of manipulation throughout my spine. It is understood and agreed the amount paid the Doctor, for X-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees he or she is responsible for all bills incurred in this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient Signature: **X** _____ Date: _____

Guardian or Spouse's
Signature Authorizing Care _____ Date: _____

WORKERS' COMP HISTORY

Patient _____

Address _____

Phone _____ Date of Birth _____

SS# _____

Employer _____

Address _____

Phone _____

Insurance Carrier _____

WCB#: _____ Carrier Case# _____

Date & Time of Injury _____

Address Where Injury Occurred _____

In your own words, state how injury occurred: _____

Were you under the care of another doctor? _____

Name _____

Address _____

Were X-rays taken? _____ Are you still under care? _____

Have you had any prior work-related injuries? _____

If yes, please explain _____

Signature

Date

IMPORTANT: Your Social Security Number Must Be Entered:

IMPORTANTE: El Numero de su Seguro Social Debe Ser Indicado:

SSN input boxes

ANSWER ALL QUESTIONS FULLY - PRINT OR TYPE CLEARLY

ACB Case No. (If Known) Carrier Case No. (If Known)

A. Injured Person: 1. Name, 2. Mailing Address, 3. Sex, 4. Do you speak English?, 5. Name of union, 6. State what your regular work/occupation was, 7. Wages or average earnings per day, 8. Were you paid full wages for the day of injury?, 9. Your work week at time of injury was:

B. Employer(s): 1. Employer, 2. Employer's Address, 3. Were you employed by any other employer or employers at the time of your injury/illness?, 4. If Yes, did you lose time from work at this other employment as a result of your injury/illness?

C. Place & Time: 1. Address where injury occurred, 2. Date of Injury, 19... at ... o'clock, AM PM

D. The Injury: 1. How did injury occur?

E. Nature and Extent of Injury: 1. State fully the nature of your injury/illness, including all parts of body injured, 2. Date you stopped work because of this injury?, 3. Have you returned to work?, 4. Does injury keep you from work?, 5. Have you done any work during period of disability?, 6. Have you received any wages since your injury?

F. Medical Benefits: 1. Did you receive or are you now receiving medical care?, 2. Are you now in need of medical care?, 3. Name of attending doctor, Doctor's address, 4. If you were in a hospital, give the dates hospitalized, Name of hospital, Hospital's address.

G. Comp. Payments: 1. Have you received or are you now receiving workers' compensation payments for the injury reported above?, 2. Do you claim further workers' compensation payments?

H. Notice: 1. Have you given your employer (or supervisor) notice of injury?, 2. If yes, notice was given orally in writing, on ... 19... to...

I hereby present my claim to the Chair, Workers' Compensation Board, for compensation for disability resulting from an accidental injury or occupational disease arising out of and in the course of my employment and not occasioned by my willful intention or solely through intoxication, and in support of it I make the foregoing statement of facts.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

Signed by... Dated... (Claimant)

(SEE OTHER SIDE FOR IMPORTANT INFORMATION - VEASE AL DORSO PARA INFORMACION DE IMPORTANCIA)

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____, ("Assignor") hereby assign to _____, ("Assignee")
(Print patient's name) (Print hospital or health care provider name)
all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____, not withstanding any other agreement to the contrary.
(Print accident date)

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

(Print name of Patient) (Signature of Patient)

(Date of signature)

(Address)

(Print name of Provider) (Signature of Provider)

(Date of signature)

(Address)

Accident Questionnaire

THE FOLLOWING INFORMATION IS REQUIRED OF ALL PATIENTS:

Has the accident been reported to the police? Yes No

If yes, did they come to the scene of the accident? Yes No

If yes, they cite anyone with a traffic violation? Yes No

If yes, whom? myself my driver the other driver

Have you reported this accident to any insurance company? Yes No

If yes, which one(s)? my own my driver the other driver's

If a claim number has been assigned, please give

Insurance Company: _____ Phone Number: _____

Claim Number: _____

Have you retained the services of an attorney? Yes No

If yes, Attorney's Name: _____

Address _____

City _____ State _____ Zip _____

Phone#: _____

The information given in this questionnaire is true and accurate to the best of knowledges

Signed _____ Date _____

PATIENT'S REPORT OF ACCIDENT

Name _____ Date _____

Location of accident _____ City _____

Date of accident _____ Time _____ Was police report made? _____

Were you: Driver Passenger Were you wearing seatbelts? _____

Were you struck from: Behind Right side Left side Front

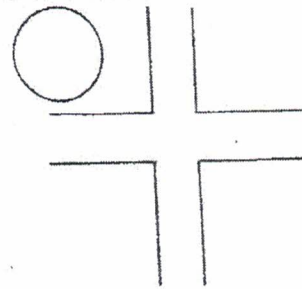
Direction of your travel _____ Other car _____ Approximate speed of your car _____ Other car _____

Kind of car you were in _____ Approximate Damages \$ _____ Other car _____ Approximate Damages \$ _____

How did the accident occur? _____

Indicate on diagram what happened

INDICATE NORTH BY ARROW



How did you feel immediately after the accident? If the injury was not noticeable right away, when did you notice any problems? _____

Have you received first aid or any other treatment for this injury? _____

If yes, from whom? _____ City _____

Were you hospitalized? _____ If yes, how long? _____ Name and city of hospital. _____

Were you off work because of this injury? _____ If yes, the first day you were unable to work _____

Have you returned to work? _____ If yes, on what date? _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on _____ and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

NOTICE OF PRIVACY PRACTICES

Victims of Abuse, Neglect, or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you \$_____ for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the Privacy Officer at your office.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

NOTICE OF PRIVACY PRACTICES

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information or treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facilities' directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Date _____