



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: _____

S Y M P T O M S

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)

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

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



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

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