



853 Broadway, Suite 1601, New York, NY 10003 (212) 777-3301

Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Work #: \_\_\_\_\_ Ext.: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_

Email: \_\_\_\_\_

\_\_\_\_ M \_\_\_\_ F \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Partnered

Emergency Contact: \_\_\_\_\_ Tel. #: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Tel. #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

Date of last physical exam: \_\_\_\_\_

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

Please list all medications you are taking: \_\_\_\_\_ Allergies: \_\_\_\_\_

Women: Are you pregnant? \_\_\_ Yes \_\_\_ No Nursing? \_\_\_ Yes \_\_\_ No Taking birth control pills? \_\_\_ Yes \_\_\_ No

**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