

PATIENT INTAKE FORM

Name: _____ (M/F) Nickname? _____

Social Security #: _____

Address _____ Apt # _____ City _____ State _____ Zip _____

Cell #: _____ Carrier (for texts instead of emails/calls) _____

Work Phone #: _____ Home Phone #: _____

Email Address: _____ DOB: _____

Marital Status: S M P D W Spouse's Name: _____ Number of Children: _____

Contact person in case of emergency contact: _____ Phone: _____

How did you hear about our office? Insurance website _____ Internet search _____ Yelp _____

Patient referral _____ Name of patient _____ Other _____

Occupation: _____ Employer: _____ Employer Address: _____

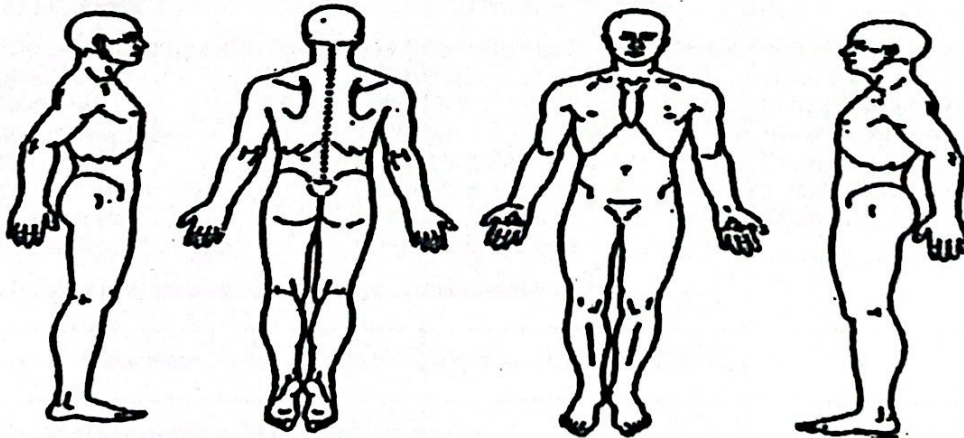
Primary Care Physician: _____ Primary Care Phone #: _____

MAIN COMPLAINT: _____ LEFT/RIGHT

OTHER COMPLAINTS: _____ LEFT/RIGHT

1. Is today's problem caused by: ☐ Auto Accident ☐ Workman's Compensation

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



3. How often do you experience your symptoms?

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

4. How would you describe the type of pain?

- ☐ Sharp ☐ Numb
☐ Dull ☐ Tingly
☐ Diffuse ☐ Sharp with motion
☐ Achy ☐ Shooting with motion
☐ Burning ☐ Stabbing with motion
☐ Shooting ☐ Electric like with motion
☐ Stiff ☐ Other: _____

5. How are your symptoms changing with time?

- ☐ Getting Worse ☐ Staying the Same ☐ Getting Better

6. 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)

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

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

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

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

9. Who else have you seen for your problem?

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

10. How long have you had this problem? _____

11. How do you think your problem began?

12. Do you consider this problem to be severe?

☐ Yes ☐ Yes, at times ☐ No

13. What aggravates your problem?

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

15. What is your: Height _____ Weight _____

16. How would you rate your overall Health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

17. What type of exercise do you do?

☐ Strenuous ☐ Moderate ☐ Light ☐ None

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

☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus
☐ Heart Problems ☐ Cancer ☐ ALS

19. Do you currently suffer from any of the conditions below? Please check all that apply.

<input type="checkbox"/> Headaches	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/> Chest Pains
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Hand Pain	<input type="checkbox"/> Muscular Incoordination
<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/> Hip Pain	<input type="checkbox"/> Visual Disturbances
<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Knee Pain	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/> High Blood Pressure	

20. List all prescription medications you are currently taking:

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

22. List all surgical procedures you have had:

23. 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

24. What activities do you do outside of work?

25. Have you ever been hospitalized? ☐ No ☐ Yes
if yes, why _____

26. Have you had significant past trauma? ☐ No ☐ Yes

27. Anything else pertinent to your visit today? _____

Patient Signature _____ Date: _____

Patient Consent for Use and Disclosure Of Protected Health Information

I hereby give my consent for Jonathan Michael D.C., P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Jonathan Michael D.C., P.C 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. Jonathan Michael D.C., P.C reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Jonathan Michael D.C., P.C at 55 Maple Ave Suite 306, Rockville Centre, NY 11570

With this consent, Jonathan Michael D.C., P.C may call my home or other 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, including laboratory results among others.

With this consent, Jonathan Michael D.C., P.C may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Jonathan Michael D.C., P.C may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Jonathan Michael D.C., P.C restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Jonathan Michael D.C., P.C 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. If I don not sign this consent, or later revoke it, Jonathan Michael D.C., P.C Jonathan Michael D.C., P.C decline to provide treatment to me.

Patient's Name

Date

Signature of Patient or Legal Guardian

Print Name of Patient or Legal Guardian

**Assignment/Direct Payment to Doctor
Private/Group Accident and Health Insurance**

Patient: _____

Primary Insurance Carrier: _____

Secondary Insurance Carrier: _____

Do you have an FSH, Flex Spending, etc. account? Yes No

I hereby instruct and direct my insurance company to pay the following provider direct payment for services rendered:

Jonathan Michael D.C., P.C.
55 Maple Ave, Suite 306
Rockville Centre, NY 11570

If policy provisions prohibit direct payment to physician, I hereby request payment for services rendered per current policy provisions. Payment is for the profession or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward charges for profession services rendered.

THIS IS DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THE POLICY.

This payment will not exceed any indebtedness to the above mentioned assignee and have agreed to pay, in current manner, any balance of said professional services charges over and above this insurance payment. A photocopy of this Assignment of Rights and Benefits shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Dated: _____

Signature of Policy Holder

SCHEDULED APPOINTMENTS

CANCELLATION/NO-SHOW POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise when another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance, you will be charged a \$30 fee; this will not be covered by your insurance company.

Print Name: _____

Signature: _____ Date: _____

LATENESS

We understand that delays can happen, however we try to keep our patients and doctors on time to assure the best possible treatment for you. We ask that you please notify us 30 minutes prior to your appointment if you are going to be late.

If a patient is 30 minutes past their scheduled time without notification, you will be charged a \$20 fee; this will not be covered by your insurance company.

Print Name: _____

Signature: _____ Date: _____