

## Female Patient Pregnancy Evaluation Form

In order for us to fully evaluate you, we may require X-rays of some part of your body. It has been found that an unborn child in its first trimester would be more sensitive to radiation than an adult. In order to insure safety, no Fetus (unborn child) be exposed to radiation from X-ray machines, we ask you to provide us with the following information. This information is strictly confidential and solely used for the purpose it is intended. Thank you for your cooperation.

Date: \_\_\_\_\_

Name: \_\_\_\_\_

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

Phone#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date of the onset of Last Menstrual Period: \_\_\_\_\_

Is there a chance you may be Pregnant? \_\_\_\_\_

To the best of my knowledge, I am not pregnant and by providing this application form, Physician/Technologist has informed me of the effects of radiation to the unborn baby and me, by signing below I have consented to taking the X-ray of my body part, pertinent for evaluation and further studies.

Signature: \_\_\_\_\_

## Confidential Patient Case History

311 W. 43<sup>rd</sup> Street  
Suite 1101  
NY, NY 10036

Name: \_\_\_\_\_ (M/F)      Nickname? \_\_\_\_\_

Social Security #: \_\_\_\_\_

Address \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell #: \_\_\_\_\_      Work Phone #: \_\_\_\_\_

Home Phone #: \_\_\_\_\_      Email Address: \_\_\_\_\_

Age: \_\_\_\_\_      DOB: \_\_\_\_\_

Marital Status: S M P D W      Number of Children: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ phone: \_\_\_\_\_

Contact person in case of emergency contact: \_\_\_\_\_ phone: \_\_\_\_\_

How did you hear about our office – please be specific? \_\_\_\_\_

Occupation: \_\_\_\_\_      Employer: \_\_\_\_\_

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

Referring Doctor: \_\_\_\_\_

**MAIN COMPLAINT:** \_\_\_\_\_ LEFT/RIGHT

**OTHER COMPLAINTS:** \_\_\_\_\_ LEFT/RIGHT

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### FOR OFFICE USE ONLY

Insurance Carrier \_\_\_\_\_ PPO/HMO    Pre-Authorization Y/N

Initial Visit X-rays Y/N    Diagnosis: \_\_\_\_\_

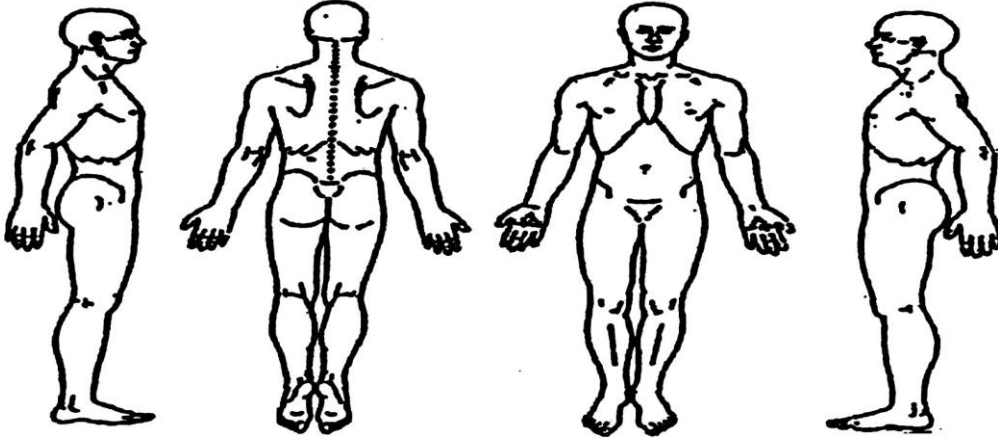
TX 1<sup>st</sup> Visit: \_\_\_\_\_

# PATIENT INTAKE FORM

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

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 \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Occupation \_\_\_\_\_

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. 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"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<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"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<b>For Females Only</b>
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue		
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination		
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances		
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness		
<input type="checkbox"/>	<input type="checkbox"/> Other: _____				

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: \_\_\_\_\_

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

Patient: \_\_\_\_\_

Insurance Policy Number: \_\_\_\_\_

Insurance Group Number: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_

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

43<sup>rd</sup> Street Physical Medicine & Rehabilitation PLLC/Westside Chiropractic  
311 West 43<sup>rd</sup> Street, Suite 1101  
New York, NY 10036

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

***Patient Consent for Use and Disclosure  
of Protected Health Information***

I hereby give my consent for 43<sup>rd</sup> Street Physical Medicine/Westside Chiropractic to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

43<sup>rd</sup> Street Physical Medicine/Westside 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. 43<sup>rd</sup> Street Physical Medicine/Westside Chiropractic 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 43<sup>rd</sup> Street Physical Medicine/Westside Chiropractic at 311 W. 43<sup>rd</sup> Street, Suite 1101 New York, NY 10036.

With this consent, 43<sup>rd</sup> Street Physical Medicine/Westside Chiropractic 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, 43<sup>rd</sup> Street Physical Medicine/Westside Chiropractic 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, 43<sup>rd</sup> Street Physical Medicine/Westside Chiropractic 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 43<sup>rd</sup> Street Physical Medicine/Westside Chiropractic 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 43<sup>rd</sup> Street Physical Medicine/Westside 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, 43<sup>rd</sup> Street Physical Medicine/Westside Chiropractic may decline to provide treatment to me.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Print Name of Patient or Legal Guardian