Female Patient Pregnancy Evaluation Form

In order or 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:_____

PATIENT INTAKE FORM

Confidential Patient Case History

311 W. 43rd Street, Suite 206-207 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

Spouse's Name: _____ Number of Children: _____

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

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

Occupation: _____ Employer: _____

Employer Address: _____

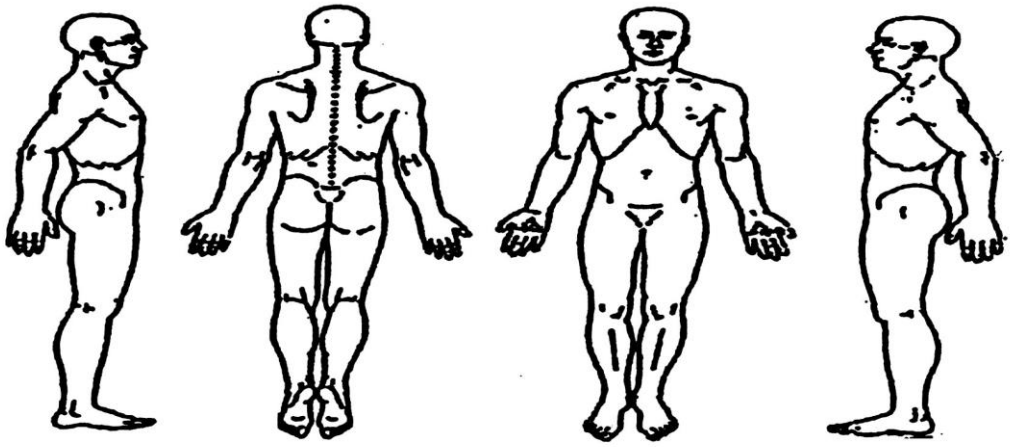
Primary Care Physician: _____ Primary Care Phone #: _____

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

☐ Headaches	☐ Wrist Pain	☐ Chest Pains
☐ Neck Pain	☐ Hand Pain	☐ Muscular Incoordination
☐ Upper Back Pain	☐ Hip Pain	☐ Visual Disturbances
☐ Mid Back Pain	☐ Upper Leg Pain	☐ Dizziness
☐ Low Back Pain	☐ Knee Pain	☐ Smoking/Tobacco Use
☐ Shoulder Pain	☐ Arthritis	☐ Other:_____
☐ Elbow/Upper Arm Pain	☐ 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?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ 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: _____

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:

43rd Street Physical Medicine & Rehabilitation PLLC/Westside Chiropractic
311 West 43rd Street, Suite 206
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 ASSIGGNMENT 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 43rd Street Physical Medicine/Westside Chiropractic to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

43rd 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. 43rd 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 43rd Street Physical Medicine/Westside Chiropractic at 311 W. 43rd Street, Suite 206 New York, NY 10036.

With this consent, 43rd 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, 43rd 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, 43rd 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 43rd 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 43rd 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, 43rd 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