PATIENT DEMOGRAPHICS

Name: **Date of Birth** _____/_____/_____

SS#:

Address:

City: State: Zip:

Home Phone #: Work #: Cell #:

Email: **Cell Carrier:**

What is the best way to contact you? ☐Cell ☐Home ☐Email ☐Text Message

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Partner

Spouse/Partner Name:

Emergency Contact Name: Phone #

Who may we thank for your **referral**?

Occupation:

Employer Name:

Insurance

Primary Card Holder Date of Birth: ___/___/___

Authorization to Release Information

I hereby authorize Robin Stein DC PC (DBA Chiropractic Care of East Islip) to release any treatment information requested by attorneys, physicians, insurance companies, employers, healthcare providers, or any other entity which may be concerned with the payment of charges incurred for the treatment of services of the doctor.

Assignment of Insurance Benefits

I hereby authorize payment directly to my provider. I am responsible for all services rendered by the clinic not covered by my insurance.

Signature: **Date:**

NOTICE OF PRIVACY PRACTICES

Consent for Purposes of Treatment, Payment and Healthcare Operations

In this document, "I" and "my" refer to the patient, and "Chiropractor" refers to Robin Stein DC PC (DBA Chiropractic Care of East Islip)

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor.

I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is always posted in the waiting room at 177 East Main Street, East Islip, NY 11730. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent to me in the mail or asking for one at the time of my next appointment.

Chiropractor uses a sign in sheet to check into appointment. You reserve the right to not sign on that board if you feel like your privacy is in question. Chiropractor will also use text messages and/or email if requested by you.

Signature: **Date:**

(Patient or Personal Representative)

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop," such as the noise when a knuckle is “cracked”, and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or traction may also be used.

Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury, or stroke, could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or other minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury, or stroke, has been estimated at one in one million to one in ten million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

Other treatment options that could be considered may include the following:

- *Over-the-counter analgesics*. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care*, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition, and make future rehabilitation more difficult.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Signature: **Date:**

177 East Main Street, East Islip NY
631-224-4764
www.chirocare-eastislip.com

WORKERS' COMPENSATION HISTORY

Name: **Date of Birth ___/___/___** **Sex:** ☐ **Male** ☐ **Female**

SS# (Required for Patient Portal): ☐Check if declining

Address:

City: State: Zip:

Workers Compensation Carrier:

Carrier Name: Phone #:

Carrier Address

City: State: Zip:

Claim #

Employer:

Employer Name:

Employer Address

City: State: Zip:

Case Information

Type of Business: Occupation:

Date of Injury Time of injury:

Are you out of work? ☐YES ☐NO Last date worked:

Previous workers comp injury: ☐YES ☐NO

Accident reported to employer? ☐YES ☐NO Name of person reported injury to:

Injury address: Location:

City: State: Zip:

Length of employment prior to injury:

Type of work being done at time of injury:

Case Information

In your own words, please describe the accident:

Have you been treated by another doctor for this accident?			☐YES ☐NO
If yes, please list doctor(s) information:			
	Name		Specialty:
	Address:		
	City	State:	ZIP:
	Name		Specialty:
	Address:		
	City	State:	ZIP:
	Name		Specialty:
	Address:		
	City	State:	ZIP:

Are you currently:		☐ Improved	☐ Unchanged	☐ Getting Worse
What medication are you currently taking for this injury?				Improvement?
	Medication #1			☐YES ☐NO ☐DON'T KNOW
	Medication #2			☐YES ☐NO ☐DON'T KNOW
	Medication #3			☐YES ☐NO ☐DON'T KNOW
	Medication # 4			☐YES ☐NO ☐DON'T KNOW
Have you had physical therapy/chiropractic?				☐YES ☐NO
	Frequency:	☐____x/week	☐Weekly	☐Monthly ☐Other
	Improvement:	☐YES ☐NO ☐DON'T KNOW		

Job Description

In terms of an 8 hour workday, “Occasionally” means 33%, “Frequently means 34%-66% and “Continuously” means 67%-

In a typical 8 hour work day, I (circle # of hours/activity)

Sit	1	2	3	4	5	6	7	8 Hours
Stand	1	2	3	4	5	6	7	8 Hours
Walk:	1	2	3	4	5	6	7	8 Hours

On the job, I perform the following activities:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Bend/Stoop	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Reach above shoulder	☐	☐	☐	☐
Crouch	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Balancing	☐	☐	☐	☐
Pushing/Pulling	☐	☐	☐	☐

On the job, I lift:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
up to 10 pounds	☐	☐	☐	☐
11-24 pounds	☐	☐	☐	☐
25-34 pounds	☐	☐	☐	☐
35-50 pounds	☐	☐	☐	☐
51-74 pounds	☐	☐	☐	☐
75-100 pounds	☐	☐	☐	☐

Job Description

Do you bend over while doing any lifting? ☐YES ☐NO

Are your feet used for repetitive movements, such as operating foot controls? ☐YES ☐NO

Do you use your hands for repetitive actions such as:	Simple Grasping	Firm Grasping	Fine Manipulation
Left Hand	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO
Right Hand	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO

Are you required to work on unprotected heights?

☐YES ☐NO If yes, describe:

Are you required to be around moving machinery?

☐YES ☐NO If yes, describe:

Are you exposed to marked changes in temperatere and humidity?

☐YES ☐NO If yes, describe:

Are you required to drive automotive equipment?

☐YES ☐NO If yes, describe:

Are you exposed to dust, fumes and/or gases?

☐YES ☐NO If yes, describe:

Prior to this accident, have you had any physical complaints similar to what you have know? ☐YES ☐NO

If yes, please describe:

Were these similar complaints the result of a previous accident? ☐YES ☐NO

If yes, please describe:

Have you had any other serious accidents which required medical care? ☐YES ☐NO

If yes, please describe

Job Description

Have you had any serious illness that required hospitalization? ☐YES ☐NO

If yes, please describe:

Have you had any surgeries? ☐YES ☐NO

Date: Procedure:

Date: Procedure:

Date: Procedure:

Date: Procedure:

Have you had any nervous or mental illness: ☐YES ☐NO

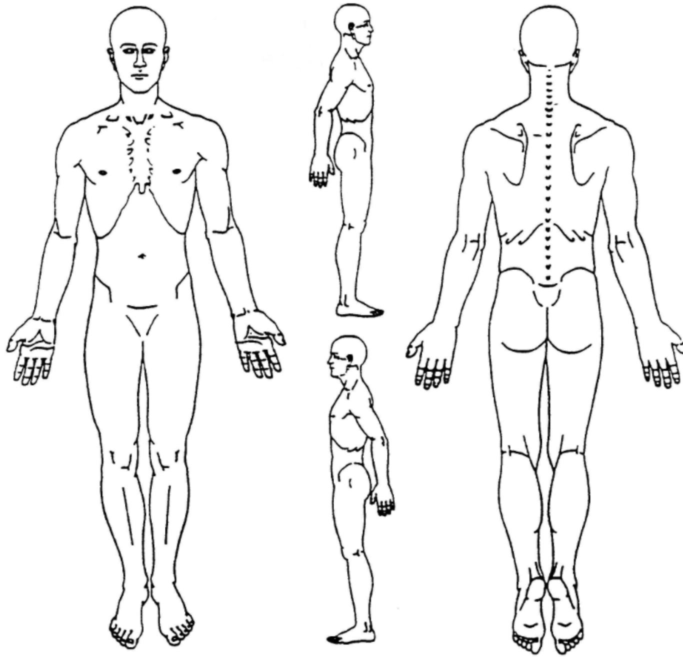
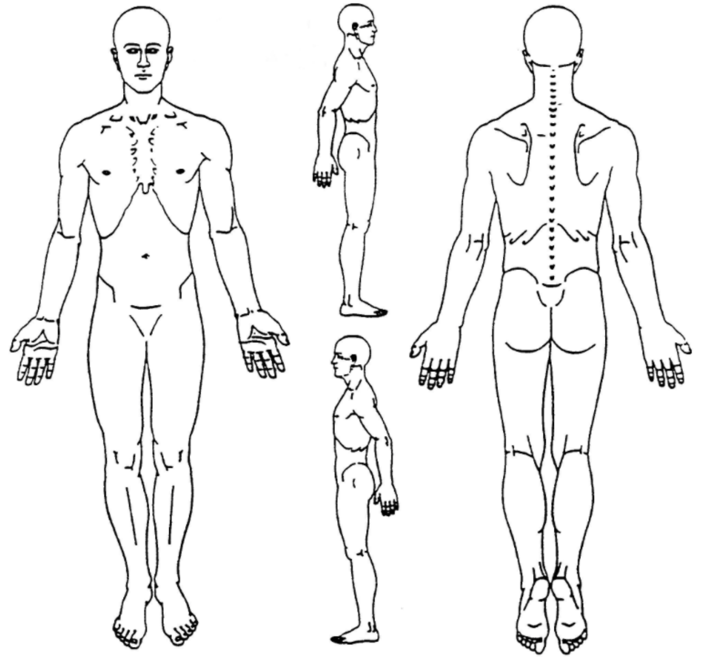
Have you had psychiatric care? ☐YES ☐NO

Have you received a medical discharge from the Armed Forces? ☐YES ☐NO

If you have returned to work since the accident, please fill out the information below

Date:	Employer	Occupation	Light/Reg Duty	Full Time/Part Time	

PATIENT INTAKE

Please draw the location of your primary complaint.	**Please draw the location of your secondary complaint (if applicable).**
	

Pain Scale: Please circle the number that describes your pain. Zero = no pain, 10 = worst pain possible

Primary Complaint		**Secondary Complaint**	
Current Pain Level:	0 1 2 3 4 5 6 7 8 9 10	Current Pain Level:	0 1 2 3 4 5 6 7 8 9 10
Average Pain Level:	0 1 2 3 4 5 6 7 8 9 10	Average Pain Level:	0 1 2 3 4 5 6 7 8 9 10
Pain at Best:	0 1 2 3 4 5 6 7 8 9 10	Pain at Best:	0 1 2 3 4 5 6 7 8 9 10
Pain at Worst:	0 1 2 3 4 5 6 7 8 9 10	Pain at Worst:	0 1 2 3 4 5 6 7 8 9 10

Primary Compliant		**Secondary Complaint**	
Frequency: ☐Constant (76-100% of the day) ☐Frequent (51-75% of the day) ☐Occasional (26-50% of the day) ☐Intermittent (1-25% of the day)		Frequency: ☐Constant (76-100% of the day) ☐Frequent (51-75% of the day) ☐Occasional (26-50% of the day) ☐Intermittent (1-25% of the day)	
When does it feel worse? ☐Morning ☐Afternoon ☐Evening ☐Night	When does it feel better? ☐Morning ☐Afternoon ☐Evening ☐Night	When does it feel worse? ☐Morning ☐Afternoon ☐Evening ☐Night	When does it feel better? ☐Morning ☐Afternoon ☐Evening ☐Night
What makes your pain better? ☐Sitting ☐Standing ☐Lying ☐Sleeping ☐Ice	☐Heat ☐Stretching ☐Medication ☐Activity ☐Other	What makes your pain better? ☐Sitting ☐Standing ☐Lying ☐Sleeping ☐Ice	☐Heat ☐Stretching ☐Medication ☐Activity ☐Other
What makes your pain worse? ☐Sitting ☐Standing ☐Lying ☐Sleeping ☐Ice	☐Heat ☐Stretching ☐Medication ☐Activity ☐Other	What makes your pain worse? ☐Sitting ☐Standing ☐Lying ☐Sleeping ☐Ice	☐Heat ☐Stretching ☐Medication ☐Activity ☐Other

Previous Imaging

Test		Date	Body Part	Hospital/Facility
X-Ray	☐Y ☐N			
MRI	☐Y ☐N			
CT Scan	☐Y ☐N			
Nerve Testing	☐Y ☐N			

General Medical Questionnaire

Have you ever had any of the following

Asthma/Breathing Problems	☐Y ☐N	Heart Disease/Disorder	☐Y ☐N
Arthritis	☐Y ☐N	Lung Disorder	☐Y ☐N
Bleeding/Clotting Disorder	☐Y ☐N	Liver Disease	☐Y ☐N
Blood Pressure Disorder	☐Y ☐N	Neurological Disorder/Chronic Headaches	☐Y ☐N
Bowel/Stomach Problems	☐Y ☐N	Psychiatric Disorder/Illness	☐Y ☐N
Cancer	☐Y ☐N	Pulmonary Embolism/DVT	☐Y ☐N
Cholesterol Disorder	☐Y ☐N	Stroke	☐Y ☐N
Diabetes	☐Y ☐N	Seizure or Epilepsy	☐Y ☐N
Eye Disorder	☐Y ☐N	Thyroid Disorder	☐Y ☐N
Gynecological Issues	☐Y ☐N	Urinary/Kidney Disorder	☐Y ☐N

Medications: Please indicate all medications you are taking for other conditions not related to your accident

Medication:	**Dosage:**

Allergies: Do you suffer from any of the following allergies?

Medication	☐Y ☐N
Food	☐Y ☐N
Environment	☐Y ☐N
No known allergies	☐

Social History: please mark all that apply

Smoking	Never	Former	Daily	Occasional		
Alcohol	☐None	☐Casual	☐Moderate	☐Heavy	☐Beer	☐Wine
Caffeine	☐None	☐<3 per day	☐3-6 per day	☐>6 per day		
Drug Use	☐Recreation	☐Addiction				
Exercise	☐Never	☐Daily	☐Weekly	☐Walk	☐Run	☐Swim
Primary Language	☐English	☐Spanish	☐Other:			
Race	☐White	☐African American		☐Asian	☐Decline	
Who do you live with?:						

Please indicate any major conditions/illnesses that your immediate family members have had:

Relative	Condition and Description	Living?	If deceased, at what age?
Mother		☐Y ☐N	
Father		☐Y ☐N	
Sibling		☐Y ☐N	
Other		☐Y ☐N	

Women Only

Any Past Pregnancies?	☐Y ☐N	How many?	How many deliveries?
Are you currently pregnant?	☐Y ☐N	If yes, how many weeks:	

Review of Systems: Please indicate ALL that apply

Constitutional

☐Y ☐N Fever	☐Y ☐N Feeling Poorly	☐Y ☐N Weight Loss	☐Y ☐N Other
☐Y ☐N Chills	☐Y ☐N Sweats	☐Y ☐N Unexp. Weight Change	
☐Y ☐N Fatigue	☐Y ☐N Weight Gain	☐Y ☐N Sleep Disturbances	

Head, Eyes, Ears, Nose, and Throat

☐Y ☐N Vision Problems	☐Y ☐N Red Eyes	☐Y ☐N Congestion	☐Y ☐N Hoarsness
☐Y ☐N Hearing Loss	☐Y ☐N Eye Pain	☐Y ☐N Snoring	☐Y ☐N Ringing in Ears
☐Y ☐N Double Vision	☐Y ☐N Runny Nose	☐Y ☐N Dry Mouth	☐Y ☐N Vertigo

Head, Eyes, Ears, Nose, and Throat

☐Y ☐N Light Sensitivity	☐Y ☐N Neck Stiffness	☐Y ☐N Flu-like Symptoms	☐Y ☐N Ear Ache
☐Y ☐N Itchy Eyes	☐Y ☐N Nose Bleed	☐Y ☐N Sore Throat	☐Y ☐N Other

Cardiovascular

☐Y ☐N Chest Pain	☐Y ☐N Leg Swelling	☐Y ☐N Cold Hands/Feet	☐Y ☐N Irreg Heart Rhythm
☐Y ☐N Palpitations	☐Y ☐N Cold Extremities	☐Y ☐N Leg Pain w/ Walking	☐Y ☐N Other

Respiratory

☐Y ☐N Shortness of Breath	☐Y ☐N Rapid Breathing	☐Y ☐N Chest Congestion	☐Y ☐N Coughing up Sputum
☐Y ☐N Cough	☐Y ☐N Wheezing	☐Y ☐N Coughing up Blood	☐Y ☐N Other

Gastrointestinal

☐Y ☐N Abdominal Pain	☐Y ☐N Diarrhea	☐Y ☐N Change in Bowels	☐Y ☐N Painful Swallowing
☐Y ☐N Blood in Stool	☐Y ☐N Black/Tarry Stools	☐Y ☐N Vomiting Blood	☐Y ☐N Other
☐Y ☐N Vomiting	☐Y ☐N Decreased Appetite	☐Y ☐N Bowel Incontinence	
☐Y ☐N Nausea	☐Y ☐N Yellow Skin	☐Y ☐N Rectal Pain	
☐Y ☐N Constipation	☐Y ☐N Trouble Swallowing	☐Y ☐N Heartburn	

Neurological

☐Y ☐N Headache	☐Y ☐N Unsteady	☐Y ☐N Numbness	☐Y ☐N Tremor
☐Y ☐N Dizziness	☐Y ☐N Disorientation	☐Y ☐N Tingling	☐Y ☐N Memory Lapses/Loss
☐Y ☐N Decreased Strength	☐Y ☐N Confusion	☐Y ☐N Seizures	☐Y ☐N Other
☐Y ☐N Poor Coordination	☐Y ☐N Burning Sensation	☐Y ☐N Fainting (Syncope)	

Musculoskeletal

☐Y ☐N Joint Pain	☐Y ☐N Limb Pain	☐Y ☐N Muscle Pain	☐Y ☐N Other
☐Y ☐N Neck Pain	☐Y ☐N Joint Swelling	☐Y ☐N Muscle Weakness	
☐Y ☐N Back Pain	☐Y ☐N Muscle Cramps	☐Y ☐N Leg Swelling	

Genitourinary

☐Y ☐N Frequent Urination	☐Y ☐N Pelvic Pain	☐Y ☐N Painful Intercourse	☐Y ☐N Heavy Period Bleeding
☐Y ☐N Incontinence	☐Y ☐N Nocturne	☐Y ☐N Discharge - Vaginal	☐Y ☐N Other

Genitourinary

☐Y ☐N Urinary Urgency	☐Y ☐N Itching - Genital	☐Y ☐N Vaginal Bleeding
☐Y ☐N Painful Urination	☐Y ☐N Change in Libido	☐Y ☐N Irreg Monthly Cycle

Integumentary

☐Y ☐N Rash	☐Y ☐N Skin Wound	☐Y ☐N Unusual Growth	☐Y ☐N Skin Cancer
☐Y ☐N Dry Skin	☐Y ☐N Change in a Mole	☐Y ☐N Itching	☐Y ☐N Other

Psychiatric

☐Y ☐N Depression	☐Y ☐N Anxiety	☐Y ☐N Other

Hematalogical/Lymphatic

☐Y ☐N Easy Bruising	☐Y ☐N Easy Bleeding	☐Y ☐N Swollen Lymph Nodes	☐Y ☐N Other

Endocrine

☐Y ☐N Excessive Thirst	☐Y ☐N Heat Intolerance	☐Y ☐N Changes to Skin
☐Y ☐N Cold Intolerance	☐Y ☐N Changes - Hair	☐Y ☐N Other

OFFICE USE ONLY: Provider Signature: ____ Date: _____________