PATIENT DEMOGRAPHICS

Name: **Date of Birth:**

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: Relationship: Date of Birth:

Primary Holder Employer:

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

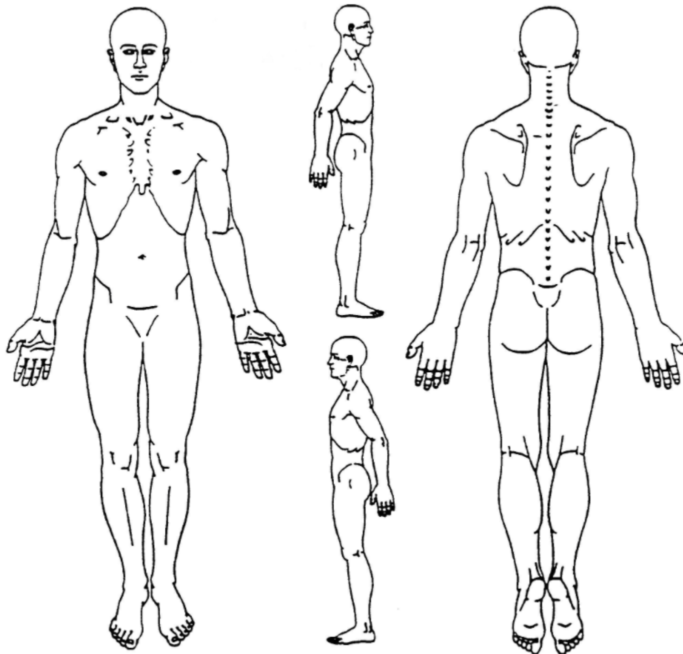
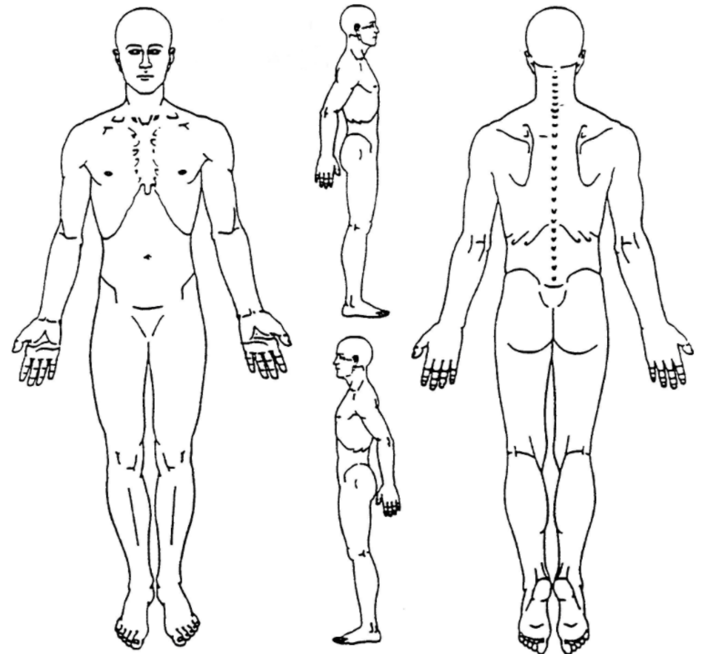
I hereby authorize payment directly to my provider. I am responsible for all services rendered by the clinic not covered by my insurance.

Signature: **Date:**

PATIENT INTAKE

Patient Name: **Date:**

Reason for todays visit?

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:	Current Pain Level:
Average Pain Level:	Average Pain Level:
Pain at Best:	Pain at Best:
Pain at Worst:	Pain at Worst:

Primary Compliant	**Secondary Complaint**
What caused your pain	What caused your pain
Onset of symptoms (Date:)	Onset of symptoms (Date:)
Are your symptoms the result of a motor vehicle accident? ☐ Y ☐ N	Are your symptoms the result of a motor vehicle accident? ☐ Y ☐ N
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?	When does it feel better?	When does it feel worse?	When does it feel better?
☐ Morning	☐ Morning	☐ Morning	☐ Morning
☐ Afternoon	☐ Afternoon	☐ Afternoon	☐ Afternoon
☐ Evening	☐ Evening	☐ Evening	☐ Evening
☐ Night	☐ Night	☐ Night	☐ Night

What makes it better?		What makes it better?	
☐ Sitting	☐ Heat	☐ Sitting	☐ Heat
☐ Standing	☐ Stretching	☐ Standing	☐ Stretching
☐ Lying	☐ Medication	☐ Lying	☐ Medication
☐ Sleeping	☐ Activity	☐ Sleeping	☐ Activity
☐ Ice	☐ Other	☐ Ice	☐ Other

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☐ Sitting	☐ Heat	☐ Sitting	☐ Heat
☐ Standing	☐ Stretching	☐ Standing	☐ Stretching
☐ Lying	☐ Medication	☐ Lying	☐ Medication
☐ Sleeping	☐ Activity	☐ Sleeping	☐ Activity
☐ Ice	☐ Other	☐ Ice	☐ Other

Previous Care: Please mark if you have seen any other specialist. ☐ **NONE**

☐ Primary Care Physician	☐ Chiropractor	☐ Physical Therapist	☐ Acupuncturist
☐ Orthopedist	☐ Physiatrist	☐ Neurologist	☐ Pain Management

Previous Imaging: Please list all previous imaging. ☐ **NONE**

Test	**Date**	**Body Part**	**Hospital/Facility**
X-Ray			
MRI			
CT Scan			
Nerve Testing			

General Medical Questionnaire: Please mark if you have/had any of the following. ☐ **NONE**

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

Medications: Please indicate all medications currently taking, and all medications taken for your current condition

Medication:	Dosage:

Allergies: Please list all allergies ☐ **NONE**

Medication:

Food:

Environment:

Surgical History: Please list all surgeries **NONE**

Date:	Surgical Procedure		