



*****Please complete each line on this form or write N/A if the line is not applicable to you.**

Patient Name: _____
(FIRST) (MI) (LAST)

Patient DOB: _____ Gender: _____ Marital Status: S M D W

Is the patient a child/minor? Yes No If YES, name of parent: _____

Address: _____

Cell: _____ Work: _____

Email address: _____ Home: _____

Employment: Unemployed Full-time Part-time Retired Student

Present Employer: _____ Occupation: _____

Primary Care Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

How did you hear about our practice? _____

****Patient Signature: X** _____ **Date:** _____

****If the patient is a minor, this signature authorizes Cary Family Chiropractic, PLLC to provide care to a minor.**

Medications/Reason for taking?

#1: _____ Reason for taking: _____

#2: _____ Reason for taking: _____

#3: _____ Reason for taking: _____

#4: _____ Reason for taking: _____

Surgeries? Date and type of surgery: _____

Pregnancies/dates? _____

Family history/prevalent diseases? _____

Lifestyle: Alcohol: _____ Tobacco: _____

Hobbies: _____

Level of exercise: _____

Diet: _____

Stress: Physical (i.e. daily activities, hobbies, repetitive motion, lifting etc.): _____

Emotional None Low Moderate High Depression Anxiety

Chemical (i.e. vitamins/supplements, medication, alcohol, lack of water, junk food): _____

What type of work do you do? _____

Do you sit or stand at work? _____

Recreational activities? _____

What position do you sleep in? (Check all that apply) Back Stomach Side

Have you been to a chiropractor before? YES NO Date of Last visit? _____

Length of treatment: _____

Reason for treatment : _____

Is this visit due to a recent Workers' Compensation injury? YES NO Date: _____

Is this visit due to a recent automobile accident? YES NO Date: _____

What other specialists have you seen for this condition? _____

Have you had radiographs of your spine within the last 10 years? YES NO

X-Ray Date: _____ Facility: _____

X-Ray Date: _____ Facility: _____

MRI Date: _____ Facility: _____

CT Scan Date: _____ Facility: _____

What areas were x-rayed? Neck Mid Back Lower Back Additional Areas

Please list the symptoms and/or pain areas (for only those symptoms that apply to you) with #10 being the most severe and #1 being the least severe. Please include mild pain areas as well.

[This diagnosis section to be filled out by staff only.]

- _____ No pain/symptoms. I want to get adjusted to stay well.
- _____ Neck Pain – Approximate Date Pain Began: _____
- _____ Upper back pain– Approximate Date Pain Began: _____
- _____ Shoulder joint pain– Approximate Date Pain Began: _____
- _____ Mid back pain – Approximate Date Pain Began: _____
- _____ Headaches – Approximate Date Pain Began: _____
- _____ Radiating pain down arm from neck – Approximate Date Pain Began: _____
- _____ Numbness/tingling describe area – Approximate Date Pain Began: _____
- _____ Radiating pain down legs: describe area _____
Approximate Date Pain Began: _____
- _____ Low back pain – Approximate Date Pain Began: _____
- _____ Hip pain – Approximate Date Pain Began: _____
- _____ Knee pain – Approximate Date Pain Began: _____
- _____ Asthma – Approximate Date Pain Began: _____
- _____ Allergies – Approximate Date Pain Began: _____
- _____ Muscle tenderness, describe area _____
Approximate Date Pain Began: _____
- _____ Tiredness/Low Energy– Approximate Date Pain Began: _____
- _____ Difficulty Walking – Approximate Date Pain Began: _____
- _____ Other radiating pain: Area From _____ Area To _____
Approximate Date Pain Began: _____
- _____ Other Complaints _____

FOR ALL PATIENTS WITH INSURANCE

If you need a receipt to submit to your insurance company, please let our office know. Initial Exam/Consultation are \$70/\$65 and all adjustments are \$50/\$55 payable at the time of the visit. We are considered an out of network provider for all insurance companies.

OFFICE POLICIES

Our mission is to provide high quality chiropractic care at an affordable cost. In order to accomplish this goal, we ask you for the courtesy of **24 hours notice for cancellations and rescheduling of appointments.** Cary Family Chiropractic, PLLC reserves the right to charge a \$25 fee for appointments *cancelled with less than 24 hours notice.* All cancellations and appointment time changes must be **made via phone only at 646-584-7252, not via text or email.**

I understand that treatments in this office are for the purpose of removing nerve interference in my body by correcting vertebral misalignments (AKA subluxations). I understand that Cary Family Chiropractic, PLLC and Dr. Jill Goldberg does not treat or diagnose any medical conditions for the purpose of diagnosing the cause of pain. If I have concerns about a medical condition, I take responsibility for contacting my medical doctor for a diagnosis.

****Patient Signature: X** _____ **Date:** _____

AUTHORIZATION/HIPPA FORM POLICY

Effective date of policy: May 1, 2013

Protected health information (PHI) will only be released from our practice with a properly executed authorization from the patient or his/her personal representative, except for treatment, payment, or health care operations (TPO) and as otherwise required by law. Examples of some instances in which we are required to disclose your PHI include:

Public health activities; information regarding victims of abuse, neglect, or domestic violence; health oversight activities; judicial and administrative proceedings; law enforcement purposes; organ donations purposes; research purposes under certain circumstances; national security and intelligence; correctional institutions; and Worker's Compensation.

Cary Family Chiropractic, PLLC will only use or disclose PHI, except as noted above, consistent with the terms of the authorization.

A patient may revoke his authorization to use or disclose PHI at any time but actions taken prior to the revocation are excluded. If authorization is a condition of obtaining insurance coverage, and the authorization is revoked, the insurer may contest a claim under the policy.

Authorizations must be properly executed by the patient or his personal representative. It should include, the date signed, specific PHI to be released or used, to whom this use or release relates, and an expiration date for the authorization.

Patient Signature: X _____ **Date:** _____

Patient Name Printed: _____

