

PATIENT INTAKE FORM

Date: _____

(PLEASE PRINT NEATLY)

Patient Name: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: Female Male Marital Status: Single Married Divorced Widowed

Home Phone: (____) _____ Cell#: (____) _____

Office# (____) _____ Email: _____

Birthdate: _____ Age: _____ Occupation: _____

Who referred you to our office? _____ Family Physician: _____

In case of emergency notify: _____ Relationship: _____

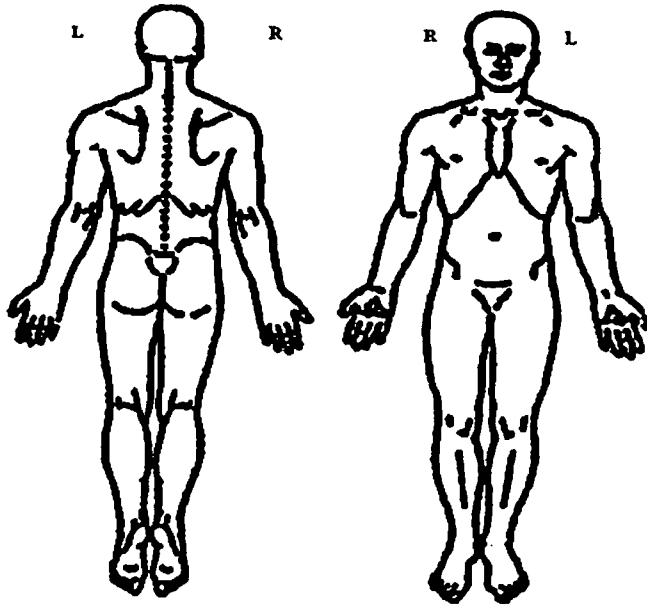
Phone (____) _____ Address: _____

1. Is today's problem caused by an injury at: Home Auto Accident Work Other

2. Indicate on the drawings below where you have pain/symptoms:

PLEASE INDICATE THE APPROPRIATE LOCATION OF PAIN AND THE SYMBOL THAT BEST DESCRIBES THE DISCOMFORT YOU ARE PRESENTLY EXPERIENCING:

SHARP & STABBING: + + + +
DULL AND ACHY: v v v v v v v v
PINS AND NEEDLES: o o o o o o
NUMBNESS: / / / / / / / / / / / / / / / / / /



3. How often do you experience your symptoms?

- | | |
|---|---|
| <input type="checkbox"/> Constantly (76-100% of the time) | <input type="checkbox"/> Occasionally (26-50% of the time) |
| <input type="checkbox"/> Frequently (51-75% of the time) | <input type="checkbox"/> Intermittently (1-25% of the time) |

4. What has helped alleviate your pain?

- Ice Heat Massage Exercise Resting Stretching Warm Bath Pain Cream
- Laying Face Down Laying on your back with knees bent Laying on your side Walking
- Pain Medication (please list): _____
- 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 the average intensity of your problem during the last 24 hours? 0 1 2 3 4 5 6 7 8 9 10 (Please circle)

6a. Using a scale from 0-10 (10 being the worst), how would you rate the average intensity of your problem over the past week? 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? (Approximate Date of Onset) _____

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 _____

16. How would you rate your overall Health?

- Excellent Very Good Good Fair Poor

17. List all prescription medications presently taking: _____

18. List all of the over-the-counter medications/Vitamins you are currently taking:

19. What type of exercise do you do?

- Strenuous Moderate Light None

20. Indicate if you have any immediate family members with any of the following:

- | | | |
|---|-----------------------------------|--------------------------------|
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> ALS |

21. List all surgical procedures you have had: _____

22. 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 | For Females Only | |
| <input type="checkbox"/> | <input type="checkbox"/> Ankle/Foot Pain | <input type="checkbox"/> | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> | <input type="checkbox"/> Birth Control Pills |
| <input type="checkbox"/> | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> | <input type="checkbox"/> Hormonal Replacement |
| <input type="checkbox"/> | <input type="checkbox"/> Joint Pain/Stiffness | <input type="checkbox"/> | <input type="checkbox"/> Ulcer | <input type="checkbox"/> | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> | <input type="checkbox"/> Arthritis | <input type="checkbox"/> | <input type="checkbox"/> Hepatitis | Last Menstrual Period | |
| <input type="checkbox"/> | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> | <input type="checkbox"/> Liver/Gall Bladder Disorder | (1st Day) _____ | |
| <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: _____ | | | | |

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

If Yes Please Describe: _____

27. Do you have any allergies? No Yes (if yes, list allergies) 1. _____ 2. _____ 3. _____

28. Anything else pertinent to your visit today? _____

I understand I am financially responsible WHETHER OR NOT MY INSURANCE COMPANY PAYS, for all charged incurred by me. I hereby assign my major medical insurance benefits, including private pay insurance, no-fault, worker's compensation and other health plans to Paul M. Salinas, D.C.. Any overpayment will be promptly refunded. I authorize Dr. Paul M. Salinas D.C., to release information required to secure payment. If a balance becomes delinquent and suit is filed, I agree to pay all collections costs, court costs, and attorney's fees in addition to the above fee. Accounts over 90 days delinquent may be subject to a monthly finance charge of 1.5% to 18% annually.

Patient Signature _____ Date: _____

Responsible Party: _____ Date: _____

CONSENT OF DISCLOSURE

I hereby give consent to Salinas Comprehensive Chiropractic, P.C. and all healthcare providers furnishing care with Paul M. Salinas, D.C. to use and disclose my protected health information for the purposes of treatment, payments and healthcare operation.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the address at the bottom of this form. This may be delivered in person or by mail, but it will be only effective when we actually receive it. Your cancellation will not be effective to the extent that we or others have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclosure of your protected health information for the purposes of treatment, payment of healthcare operation. We are not required to grant your request, however, if we do, the restriction will be obligatory to us.

Our Posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our Posted Privacy Policy. You may obtain a copy of the current policy by requesting a copy via mail, or emailing us at info@parkavenuespine.com

I acknowledge that I have read and I fully understand this Consent of Disclosure.

Print Name: _____

Signature of Patient: _____ Date: _____

If you are signing as the patient's representative or parent/guardian:

Print Name: _____

Relationship: _____

Signature: _____

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