Dear Patient:

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Telephone _____ Work Telephone _____

Email Address _____ Fax # _____ Pager _____

Age _____ Birthdate _____ # Children _____

Marital Status: M S W D Occupation: _____

Spouse's Name _____ Spouse's Office Telephone _____

Referred by _____ Nearest Relative & Telephone _____

HEALTH INFORMATION: Have you had previous chiropractic care? _____

What is your major complaint? _____

_____

Other Complaints: _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? Yes ☐ No ☐ Constant ☐ Comes and goes ☐

Is this condition interfering with you: Work ☐ Sleep ☐ Daily routine ☐ Other _____

How long has it been since you really felt good? _____

Other doctors who treated this condition _____

_____

List surgical operations and years: _____

_____

Drugs you now take: ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers ☐ "Pep" pills ☐ Tranquilizers

☐ Insulin ☐ Birth control pills ☐ Others _____

Age of mattress____ ☐ Comfortable ☐ Uncomfortable

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner Soles ☐ Arch supports

Have you been in an auto accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

Describe: _____

Have you had any other personal injury or accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years

☐ None

Describe: _____

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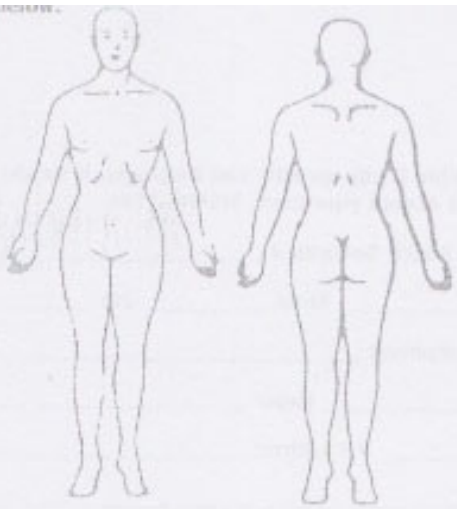
below:



1. Dizziness _____
2. Backaches _____
3. Heart Trouble _____
4. Diabetes _____
5. Arthritis _____
6. Headaches _____
7. Asthma _____
8. Neuritis _____
9. Digestive Disorders _____
10. Nervousness _____
11. Sinus Trouble _____
12. Neck Pain _____

INSURANCE INFORMATION:

Is your condition due to an auto accident or job related injury? Yes ☐ No ☐

Do you have Health Insurance? Yes ☐ No ☐

If Yes, Name of Company? _____ Policy# _____

Are you covered by Medicare? Yes ☐ No ☐

If Yes, Health Insurance # _____

I understand and agree that health and accident policies are an arrangment between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare an necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon recepit. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered mewill be immediately due and payable.

I will be paying today by ☐ Cash ☐ Check ☐ Credit Card

☐ Mastercard ☐ Visa ☐ American Express Card# _____ Exp Date _____

All accounts not paid within 90 days will automatically be put through on your credit card.

Patients Signature: _____ Date _____

Guardian or Spouse's Signature: _____ S.S.# _____

Doctor's Signature: _____

FAMILY HEALTH INFORMATION. (Many health problems are the result of hereditary spinal weaknesses; thus information abot your family members will give us a better picture of your total health picture.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

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Heath Insurance Privacy Policy Act

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices.

We are required to abide by the terms of this notice as long as it is currently in effect.

We reserve the right to revise this notice, and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our office and copies will be available there.

If you want to complain about violations of your privacy rights, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the United States. You may also file a complaint with us. Complaints should be directed to East Park Chiropractic. 714 East Park Avenue, Long Beach, NY 11561

Or retaliatory action will be taken against you for any complaint you may make.

I have received a paper copy of this notice.

_____

Signature

_____

Print Name

_____

Date

I would like to make the following special request for confidential communications:

_____

_____

_____

_____

_____

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