

**Health Questionnaire**

**Patient Title: (check one) Mr. Mrs. Ms. Miss Dr. Prof.**

**First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­ Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Phone/Mobile: ( ) \_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_ Secondary Phone: ( ) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*By providing my email address, I authorize Upper Cervical Chiropractic of New York, PC to contact me via the email address(es) provided.*

**Referred by: Patient/Friend Physician Advertisement Community Event**

**Name of Person or Event: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_ Gender: (Check one)** Male Female

**Marital Status:** *(Check one)* Single Married Widowed Divorced Other

**Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

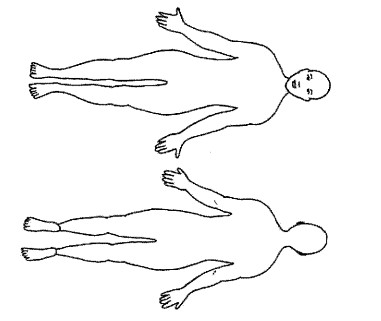
**Employment Status:** *(Check one)*  Employed Retired Self- Employed Other

**Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact Information: Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***PLEASE BE AS SPECIFIC AS POSSIBLE***

Main/Chief complaint:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did it start: (Date)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes it better?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes it worse?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe the pain:

Sharp ⁭Dull ⁭Aching ⁭Burning ⁭Throbbing Numbing Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pain is:

Occasional ⁭Intermittent ⁭Frequent Constant

Mostly at night ⁭In the morning

Pain is present: 25% 50% ⁭75% ⁭100% of the time

On a scale of 0 to 10, with 0 being no pain and 10 being severe and debilitating pain, how would you describe your pain at its worst?

0⁭ 1 ⁭ 2 ⁭ 3 ⁭ 4 ⁭ 5 ⁭ 6 ⁭ 7 ⁭ 8 ⁭ 9 ⁭10

Additional Information: (Accidents, falls, surgeries, hospitalizations, and/or in-patient treatments)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Information: Medications

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please **CIRCLE** the conditions you have experienced within the past year:

**Skin and Hair**

|  |  |  |  |
| --- | --- | --- | --- |
| Rashes | Eczema/Psoriasis | Skin color change | Warts |
| Ulcerations | Dandruff | Acne | Fungal Infection |
| Hives/Allergic Dermatitis | Loss of hair | Face Flushing | Excessive sweating |
| Itching | Moles | Dermatitis | Change in hair/skin texture |

**Head, Eyes, Ears, Nose, and Throat**

|  |  |  |  |
| --- | --- | --- | --- |
| Night Blindness | Frequent Sore Throat/Cold | Double Vision | Poor Hearing |
| Difficulty Swallowing | Migraines | Nose Bleeds | Cataracts |
| Headaches | Glaucoma | Earaches | Sinus Problems |
| Eye Strain | Ringing in Ears | Dryness in Eyes | Jaw Clicks/locks |
| Blurred/Poor vision | Eye Pain | Grinding Teeth | Facial Pain |

**Cardiovascular**

|  |  |  |  |
| --- | --- | --- | --- |
| Chest Pain or Pressure | Low Blood Pressure | Swelling of Hands/Feet | High Blood Pressure |
| Spontaneous Sweating | Fainting | Angina | Irregular Heart Beat |
| Varicose/Spider Veins | Cold Hands | Blood Clots |  |

**Respiratory**

|  |  |  |  |
| --- | --- | --- | --- |
| Cough/Wheezing | Asthma | Coughing Blood | Difficulty Breathing |
| Pneumonia | Shortness of Breath | Bronchitis | Pain with Inhalation |

**Musculoskeletal**

|  |  |  |  |
| --- | --- | --- | --- |
| Joint Pain/Stiffness | Back Pain | Muscle Pain/Cramps | Sciatica |
| Muscle Weakness | Sprains/Strains | Neck Pain | Broken Bones |

**Gastrointestinal**

|  |  |  |  |
| --- | --- | --- | --- |
| Changes in Appetite | Gas/ Constipation | Indigestion | Blood in Stool |
| Bloating/Edema | Vomiting | Gall Bladder Disease | Blood in Urine |
| Loose Stools/Diarrhea | Hemorrhoids | Nausea | Abdominal Pain/Cramps |
| Rectal Pain | Hernia | Acid Reflux | Ulcers |

**Neuropsychological**

|  |  |  |  |
| --- | --- | --- | --- |
| Seizures/Fainting | Alcoholism | Addiction | Depression |
| Anxiety/Panic Attacks | Nervousness | Tension/Stress | Lack of Coordination |

**Chiropractic Care Statement (all patients)**

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. A chiropractic adjustment is a specific manipulation to facilitate the body’s correction of vertebral subluxation (a misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of proper healthy nerve function).

We do not diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment of those findings, we will recommend that you seek the services of another health care provider. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including diagnostic X-rays, and SoftWave therapy, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic. I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

(print name) (signature) (date)

**Pregnancy Release (all female patients)**

This is to certify that to the best of my knowledge, I am not pregnant and the doctor has my permission to perform an, x-ray evaluation. I have been advised that x-ray during pregnancy can be hazardous to the fetus.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

(print name) (signature) (date)

I am, or may be pregnant, and the doctor has my permission to perform cervical x-rays with the use of filters.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

(print name) (signature) (date)

**Consent to Evaluate and Adjust a Minor Child (parent/guardian of all patients under age 18)**

I am the parent or legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and have read and fully

(print minor’s full name)

understand the above terms of acceptance. I hereby grant permission for my child to receive chiropractic care.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

(print name) (signature) (date)

**I certify that this profile is complete to the best of my knowledge. I understand that providing false information or leaving out pertinent information may compromise the quality of medical care I receive.**

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notice of Privacy for:**

**Patient’s Protected Health Information**

This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

**This office abides by the terms described in this policy:**

This office uses and discloses your protected health care information for the following:

* To share with other treating health care providers regarding your health care.
* To submit to insurance companies or Worker’s Compensation to verify that treatment has been rendered.
* To determine patient’s benefits in a health care plan.
* Releasing information required by State or Federal Public Health Law.
* To assist in overcoming a language barrier when caring for a patient.
* Business associates providing written assurances for your privacy have been attained.
* Emergency situations
* Abuse, neglect, or domestic violence
* Appointment reminders to household members or answering machines
* Sign-in logs may be disclosed to verify office visits.
* To send out birthday cards and newsletters

***Any other uses or disclosures will only be made with your specific written prior authorizations.***

**You have the right to:**

* Revoke authorization, in writing at any time by specifying what you want restricted and to whom.
* Inspect, copy and amend your protected health information and amend it as allowed by law.
* Obtain an accounting of disclosures of your protected health information.
* To render a complaint to our privacy officer

This office reserves the right to change the terms of this notice and make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received and reviewed this notice with full understanding.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient Signature of Patient/ Legal Representative Date

***Upper Cervical Chiropractic of New York, PC***

311 North Street, Suite 410

White Plains, NY 10605

Telephone: (914) 686-6200 Fax: (914) 686-6237

**Office Policies**

***Office Hours***

Monday: 8am – 12pm & 2pm – 6pm

Tuesday: 8am – 12pm & 2pm – 6pm

Wednesday: 8am – 12pm **SoftWave ONLY** Thursday: 8am – 12pm & 2pm – 6pm

Friday: **CLOSED**

Saturday: 8am - 11am

***Scheduling an Appointment .*** We attempt to schedule appointments to accommodate our patients' needs. The welfare and consideration of our patients is our primary concern. We do not overbook appointments and keep you waiting for long periods to be seen. We do spend time getting to know our patients, answering their questions and educating them for achieving maximum results in the shortest possible time. We also make every effort to see patients at scheduled appointment times, as we realize that your time is valuable. We do ask in return, that you make appointments in advance as we do not accept walk ins.

***Cancelling an Appointment.*** If you cannot keep your appointment, please give us at least 24 hours notice. This courtesy on your part will make it possible to give your appointment to another patient. We reserve the right, at our discretion, to charge you $15 for each missed appointment. Additionally, if you will be unavoidably late for your appointment, please call us to let us know. If you arrive very late, we may need to reschedule your appointment.

***Insurance Policy.* Our Patients tend to be health conscious consumers who do not make all their health care**

**choices on what is covered by insurance.** Due to changes in health insurance fees, patient self billing has become a much more cost effective way for you, the patient, to get reimbursement for your care. Self billing allows us to keep our fees low so you can get the care you need without any added cost. *Therefore, our policy is that all payment is due at the* *time of service and bills will no longer be sent to your insurance provider.* Statements will be provided for individuals to submit their own bills ensuring that as your insurance provider pays for your care, they will send the reimbursement check directly to you. We do act as a resource to help you obtain the information you need from us to file your insurance forms. Please note we are not responsible for any determination made by the insurance company about reimbursement. Please inquire with the office staff for further information.

***Payment For Services.*** Unless other arrangements are made, payment for services is due at the time of your visit. We will accept cash, major credit cards, and personal checks for payment*.* For other payment arrangements, please see our office manager prior to your appointment.

***Confidentiality****:* ***Your medical information is strictly confidential. We will not release it to anyone without your***

***written consent. A family member may, however, accompany you to your appointments if you wish. If you want a copy of your records sent to another doctor, we will require a written authorization from you. As required by law, you will receive a separate notice of our Privacy Practices.***

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/ \_\_\_\_\_ /\_\_\_\_\_