CHIROPRACTIC FORM

HUDSON VALLEY CHIROPRACTIC & NUTRITION OFFICE
PATIENT INTAKE FORM

475 Tuckahoe Road Suite 200
Yonkers, NY 10710
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Disclaimer: Thank you for your interest in being a patient of our office. Information collected about new patients is confidential and will be treated accordingly.

Patient Name: ________________________________
Date of Birth: ____________
SSN: __________________ **Sex**: Male Female Other: ____________
Street Address: ____________________________________
City: __________________ **State**: __________________ **ZIP Code**: _______
Home Phone: __________________ **Mobile Phone**: __________________
Work Phone: __________________ **E-Mail**: __________________
# of Children: ____ **Marital Status**: Single Married Divorced Widowed
Employer (if any): __________________ **Job Title**: __________________
Primary Physician: __________________ **Phone**: __________________
Have you been to a chiropractor before? Yes No

- If so, how long ago? ____________ Where? ______________________

Emergency Contact Information

Emergency Contact: __________________ **Phone**: __________________
Relationship to Patient: __________________

INSURANCE POLICIES

Primary Insurance Company: __________________
Group #: __________________ **ID #**: __________________
Policyholder Name: __________________ **Date of Birth**: ____________
Relationship to Patient: __________________

Secondary Insurance Company: __________________
Group #: __________________ **ID #**: __________________
Policyholder Name: __________________ **Date of Birth**: ____________
Relationship to Patient: __________________

SYMPTOMS

Purpose of this appointment:

____

____

List the areas on your body where you experience pain:

____

____

____

Describe your symptoms in order of severity, beginning with the worst symptom:

____

____

____

How long ago did your symptoms begin? __________________________________

What caused your symptoms? Motor Vehicle Accident Work Accident Other

- If other, explain: ____
- Major Accidents/Falls?____

How often do your symptoms occur?

Constantly (76%-100% of the day) Frequently (51%-75% of the day) Occasionally (26%-50% of the day) Intermittently (0%-25% of the day)

What makes your symptoms better? _____________________________________

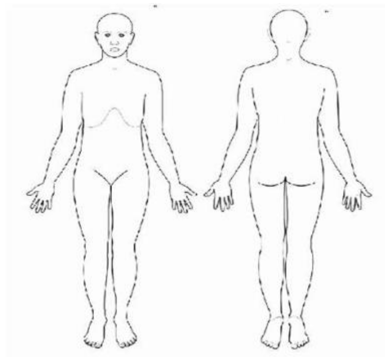
What makes your symptoms worse? _____________________________________

Other doctors seen for this condition? _________________________________

Disabled from work and dates? ______________________________________

Are you taking:

Nerve Pills



PATIENT HEALTH HISTORY

Indicate the medical conditions that you have had:

Other_______________

Gastro-Intestinal Codes:

Abdominal Cramps

Do you smoke cigarettes? Yes No
- If yes, how many cigarettes per day? _____

Do you chew tobacco? Yes No
- If yes, how often? Frequently Occasionally Rarely

Do you drink caffeine? Yes No
- If yes, how many cups per day? _____

How often do you exercise? Frequently Occasionally Rarely Never

How often do you wear a seatbelt? Always Occasionally Never

By signing below, I hereby acknowledge, agree, and authorize all of the following:

a) **Accurate Information.** I certify that the information provided on this form is accurate, complete, and up to date to the best of my knowledge.

b) **Patient Rights and Responsibilities**. I understand that the healthcare facility maintains a Notice of Privacy Practices, which describes how my protected health information may be used and disclosed, and how I may access my health records. I understand that I have the right to review this healthcare facility's Notice of Privacy Practices prior to signing this form.

c) **Release of Medical Information**. I authorize the release of my health information to the healthcare facility in accordance with the healthcare facility's Notice of Privacy Practices. This includes, but is not limited to, releasing medical information to my referring physician, primary care physician, and any physician(s) I may be referred to. The healthcare facility shall ensure all health information remains confidential, as required by HIPAA, and will not release any of my health information without my consent.

d) **Consent for Treatment**. I grant the healthcare facility, including its affiliated providers, physicians, and other medical personnel, permission to use the health information provided for the purpose of my medical treatment as necessary.

e) **Consent to Communication**. I consent to receiving communications from the healthcare facility regarding appointment reminders, test results, and other necessary healthcare-related information via phone, email, or other channels.

f) **Acknowledgment.** By signing below, I hereby acknowledge, agree, and authorize all of the above, and I authorize the healthcare facility to retrieve and review my medical history and authorize the healthcare facility to release the information required in obtaining procedure authorization or the processing of any insurance claims.

Patient Signature: ______________________ **Date**: ________________

Print Name: ______________________

Parent or Guardian Signature: ______________________ **Date**: ________________

Print Name: ______________________