EAST VILLAGE CHIROPRACTIC 33 East 7th Street New York, NY 10003 212 260-2213

Confidential Health Questionnaire

Patient Name_____**Sex: Male Female Today's Date** _____

Home Address_____ **City** _____**State** _____ **Zip**_____

Home Phone_____ **Cell/Additional Phone** _____

Work Phone_____ **Date of Birth**_____ **E-mail**_____

Social Security #_____ **If married – Spouse's name** _____

Occupation _____ **Job Duties** _____ **Job Stress Lever (1-10)**_____

I live and/or work in the East Village area? Yes☐ No☐ Hobbies _____ **Smoker ☐ Yes ☐ No**

1. Reason for Visit _____

2. Please describe your current symptoms _____

_____

3. Date symptoms began _____**Related to** ☐ Work Injury ☐ Auto Accident ☐ Other _____

4. Describe how your symptoms began _____

_____

5. How often do you experience your symptoms?
- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

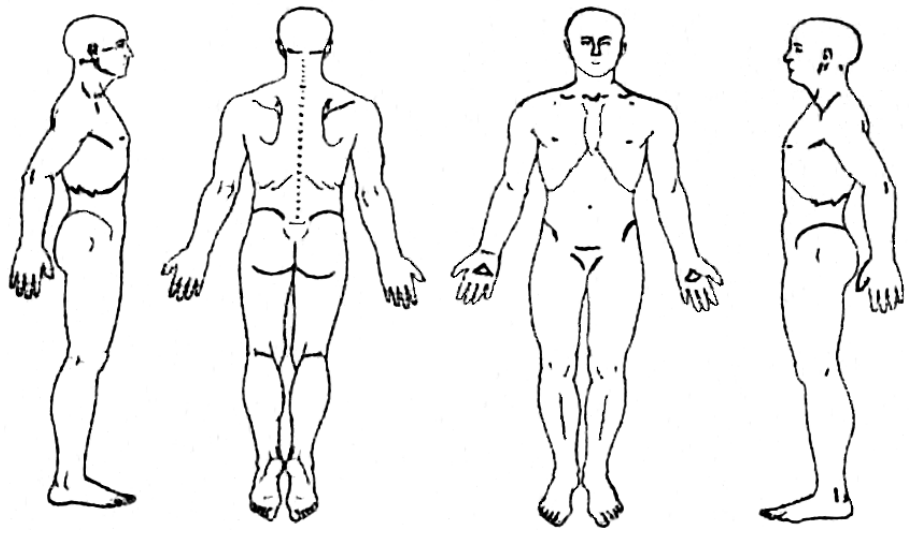
6. What describes the nature of your symptoms?
- ☐ Sharp ☐ Shooting
- ☐ Dull ache ☐ Burning
- ☐ Numb ☐ Tingling

7. How are your symptoms changing?
- ☐ Getting Better
- ☐ Not Changing
- ☐ Getting Worse

8. Current medications: ☐ Advil ☐ Tylenol

☐ Other/s _____

Indicate where you have pain or other symptoms



None (Check One) Unbearable

9. Indicate the average intensity of your complaints ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

10. What makes your symptoms feel better? _____

11. What makes your symptoms feel worse? _____

13. Who have you seen for your current symptoms? ☐ No one ☐ Medical Doctor ☐ Osteopath ☐ Physical Therapist ☐ Chiropractor ☐ Other_____

a. Tests performed? ☐ X-rays date _____ ☐ CT scan date_____☐ MRI date: __ _____☐ Other, date _____

b. Describe treatment _____

13. Have you had similar symptoms in the past? ☐ No ☐ Yes (explain) _____

_____

a. Who did you see? ☐ No one ☐ Medical Doctor ☐ Physical Therapist ☐ Osteopath ☐ Other Chiropractor ☐ This Office

14. How did you here about our office? ☐ Walked by ☐ Yellow pages ☐ Web site: (which one) _____

☐ Other _____ ☐ Friend is a patient ☐ Family member is a patient ☐ Medical doctor ☐ Chiropractor

15. **Whom may we thank for referring you?** _____

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Claim Information

Is your condition due to: ☐ Auto accident ☐ Personal injury ☐ Work injury ☐ Other _____

Type of Health coverage: ☐ Health insurance ☐ Medicare ☐ Worker's compensation

I will be paying today by: ☐ Cash ☐ Check ☐Visa ☐ MasterCard

☐ Discover ☐ American Express

Do you have insurance? ☐ Yes ☐ No

Insurance information

Insurance company _____

Relationship to insured ☐ Self ☐ Child ☐ Spouse - name of spouse _____spouse's date of birth _____

Authorizations

I hereby authorize release of any medical information necessary to process and request payment of insurance benefits either to myself or the party who accepts assignment.

I authorize payment of any medical benefit from third party parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of the proceeds of any settlement of my case and by insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore I understand that this office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. _____
(Please initial)

I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable by me.

Patient's/Guardian's Signature _____

Date_____

Please check any symptoms you have or have been experiencing within the last 6 months

Nervous System
difficulty expressing yourself _____
difficulty concentrating _____
short temper _____
anxiety _____
stress _____
numbness/tingling arms/legs _____
burning in arms/legs _____

Immune System
allergies _____
colds/flu often _____
sinus problems _____
ear/throat infections _____

Respiratory System
episodes of difficulty breathing _____
asthma or bronchitis _____

Circulatory System
cold fingers/toes _____
heart problem _____
blood pressure high/low _____

Excretory system
constipation/diarrhea _____
bladder infections _____
bladder control problems _____
kidney problems _____

Digestive system
heart burn _____
reflux _____
ulcers _____
Colitis _____
Colic _____

Muscular System
spasm/swelling _____
poor posture _____
scoliosis _____
back/neck aches/pain _____

Miscellaneous
fatigue _____
hyperactivity _____
headaches/migraines _____
attention deficit disorder _____
bedwetting _____
diabetes _____

Females
irregular/absence of menstrual cycle_____
moderate to severe cramps _____

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA)

On December 20th 2000, the federal government issued the final regulations on the Health Insurance Portability and Accountability Act (HIPAA). These rules were published in the Federal Register on December 28th 2000.

These new regulations established broad privacy protection for an individual's health record. The regulations apply virtually all-personal information, whether documented on electronic records, on paper or through communications.

These rules require physicians to obtain a one-time advance written consent from their patients for the routine use and disclosure of their health data. Routine use, as defined by the Act, includes accessing a patient's confidential information for treatment purposes, discussing a patient's care with other physicians and medical personnel, forwarding the information to an insurance carrier for the purpose of payment and/or in compliance with rules established by the patient's own health plan.

I consent to the use and disclosure of my protected health information by East Village Chiropractic for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct health care operations. I understand that analysis, diagnosis or treatment of me by East Village Chiropractic may be conditioned upon my consent as evidence by my signature below.

I understand I have the right to request restrictions as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operation of the practice. East Village Chiropractic is not required to agree to the restrictions that I may request. However, if East Village Chiropractic agrees to a restriction that I request, the restriction is binding. I have the right to revoke this consent, in writing, at any time, except to the extent that East Village Chiropractic has taken action in reliance on the consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information identify me.

I have been provided with a copy of the Notice of Privacy Practices and understand that I have a right to read the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of East Village Chiropractic. The Notice of Privacy Practices for East Village Chiropractic is also posted in the waiting room 33 E 7 Street, New York, NY 10003. This Notice of Privacy Practices also describes my right and duties of East Village Chiropractic with respect to my protected health information.

East Village Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of East Village Chiropractic and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Your signature below establishes that all use of your medical information for the above purpose is authorized and serves to document this office's compliance with the new HIPAA regulations.

Patient Name _____ Date _____
(Please Print)

Patient Signature _____ _____
(or guardian if the patient is a minor) Relationship