NORTHEAST SPINE & WELLNESS CENTER

PATIENT INFORMATION

Name:		Age		Gender: ☐ M ☐ F	Birth Date:		
Home Address:		City:		State:		Zip:	
Home Phone:		Work:		Mobile:			
Email Address:		SSN#		Marital Status:	☐S ☐M ☐D ☐W		
Occupation:		Employer Name:					
Spouse's Name:		Work Phone:		Cellphone:			
Spouse's Employer:		Occupation:					
Emergency Contact:		Phone:					
Relationship to Patient:							

Who/How were you referred to this office?

PURPOSE OF THIS VISIT

Your Symptoms	☐ Back Pain	☐ Neck Pain	☐ Shoulder Pain	☐ Knee Pain	☐ Wrist Pain	☐ Foot Pain	☐ Hip Pain					
	☐ headaches	☐ Weight gain	☐ Snoring	☐ Sleep problems	☐ Other							
How long ago did your troubling symptoms start?	☐ 1-2 Weeks	☐ 2 Wks -2 mrhs	☐ 2-6 mths	☐ 6-12 mths	☐ Other							
What Happened												
Is this condition related to:	☐ Auto Accident	☐ Work Injury										
If so, date of injury												
Please circle your worst pain level in the past couple of days:	(Mild)	0	1	2	3	4	5	6	7	8	9	10 (Severe)
Is this condition getting worse?:	☐ YES	☐ NO										
Is this condition:	☐ Constant	☐ Comes & goes	☐ Activity related									
What aggravates symptoms?	☐ Driving	☐ Reaching	☐ Lifting	☐ Reading	☐ Stairs	☐ Walking	☐ Sitting	☐ Standing	☐ Prolonged Positioning			
Prior level of function	☐ Normal/No complaints	☐ Limits										
Does complaint(s)interfere with:	☐ Work	☐ Sleep	☐ Hobbies	☐ Daily Routine								
Explain:												
Is there anything which has relieved your symptoms?	☐ YES	☐ NO										
Describe:												
Have you experienced this condition before?	☐ YES	☐ NO										
If so, please explain:												
Whom have you seen for this?												
What did they do?												

EXPERIENCE WITH CHIROPRACTIC • PT • ACUPUNCTURE • INJECTION

Have you seen a Chiropractor before?	☐ YES ☑ NO	Who?		When?	
Reason for visits:					
How did you respond?	☐ Better ☐ Worse ☐ No Change				
Did your previous chiropractor take before and after x-rays?	☐ YES ☐ NO				
Have you seen a Physical Therapist before?	☐ YES ☐ NO	Who?		When?	
Reason for visits:					
How did you respond?	☐ Better ☐ Worse ☐ No Change				
Have you seen an Acupuncturist before?	☐ YES ☐ NO	Who?		When?	
Reason for visits:					
How did you respond?	☐ Better ☐ Worse ☐ No Change				
How did you respond?	☐ YES ☐ NO ☐ Steroid ☐ Fluid Supplement				

Medication list:

Please list any allergies to food and/or medication:

Height:		Weight:	

Past Medical History:

☐ Alcoholism	☐ CVA	☐ Liver Disease
☐ Anemia	☐ Dementia/Alzheimer's	☐ Migraine
☐ Anxiety	☐ Disc Disease	☐ Multiple Sclerosis
☐ Arrhythmia	☐ DJD	☐ Nephrolithiasis
☐ Arthritis	☐ Depression	☐ Obesity
☐ Asthma	☐ DM Type I	☐ Osteoarthritis
☐ Atrial Fibrillation	☐ DM Type II	☐ Osteoporosis
☐ Bronchitis	☐ Emphysema	☐ Prior MI
☐ CAD	☐ Epilepsy	☐ Pulmonary Disease
☐ Cancer	☐ Fracture	☐ Rheumatoid Arthritis
☐ Cardiovascular Disease	☐ GERD	☐ Seizures
☐ CHF	☐ Glaucoma	☐ Sickle Cell Disease
☐ Crohn's Disease	☐ Gout	☐ STD
☐ Cirrhosis	☐ Hepatitis	☐ Systemic Lupus Erythematosus
☐ Colitis	☐ High Cholesterol	☐ Thyroid Disease
☐ Constipation	☐ Hyperlipidemia	☐ TIA
☐ COPD	☐ Hypertension	☐ Tuberculosis
☐ CRF	☐ Implanted Medical Devices	☐ Ulcers
	☐ Kidney Disease	☐ Valve Problems

Past Surgical History:

☐ No Prior Surgery	☐ Mastectomy	☐ Total Knee Replacement
☐ Appendectomy	☐ Shoulder Surgery	☐ Left ☐ Right
☐ D&C	☐ Spinal Surgery	☐ Total Hip Replacement
☐ Hysterectomy	☐ Tonsillectomy	☐ Tubal Ligation
☐ Knee Arthroscopy		
☐ Lef ☐ Right		

Tobacco Assessment:

Smoking status	**Tobacco user:**
☐ Yes ☐ No	☐ Yes ☐ No

Social History:

Alcohol	**Children**	**Psychiatric Diagnoses**
☐ Yes ☐ No	☐ Yes ☐ No	☐ Major Depression
Drug use	**Work Status**	☐ Generalized Anxiety
☐ Yes ☐ No	☐ Employed	☐ Bipolar
Marital Status	☐ Unemployed	☐ Schizophrenia
☐ Married		☐ Other _____
☐ Single		☐ None
☐ Divorced		

Family History:

☐ Ankylosing Spondylitis	☐ COPD	☐ Liver Disease
☐ Arthritis	☐ Crohn's Disease	☐ Myocardial Infarction
☐ Alcoholism	☐ CVA/TIA	☐ Osteoarthritis
☐ Anemia	☐ Depression	☐ Osteoporosis
☐ Anxiety	☐ Diabetes	☐ Psoriasis
☐ Asthma	☐ Epilepsy	☐ Pulmonary Disease
☐ Bleeding Disorder	☐ GERD s	☐ Renal Disease
☐ CAD (Coronary Artery Disease)	☐ Gout	☐ Rheumatoid Arthritis
☐ CHF (Congestive Heart Failure)	☐ Hypertension	☐ SLE (Systemic Lupus Erythematosus)
☐ Cancer	☐ Kidney Disease	☐ Thyroid Disease
☐ Colitis		

CARE AUTHORIZATION & X-RAY CONSENT

I, _____, authorize and agree to allow the doctor, physical therapist and/or acupuncturist to work with my spine and/or extremities through the use of spinal adjustments, manual therapies, modalities and rehabilitative exercises for the purpose of restoration of normal biomechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided and agree to ensure full payment of all charges.

My health care providers will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural or extremity conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctor's, physical therapist's and/or acupuncturist's specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time, I authorize the assignment of all insurance benefits to be directed to the doctor, physical therapist and/or acupuncturist for services rendered.

I give my consent to allow Northeast Spine & Wellness Center, as deemed appropriate by the examining physician, to take radiographs (x-rays) of my spine and/or extremities. I affirm that to my knowledge that I am not pregnant. (Initial)

Patient's Signature	Date

I hereby authorize Northeast Spine & Wellness Center to administer care as deemed necessary to my child or dependent, a minor under the age of 18 years old.

Parent/Guardian's Signature	Date

NOTICE OF PRIVACY PRACTICES

We care about our patients' privacy and are committed to protecting the confidentiality of your personal and medical information. We are required by law to maintain the privacy of protected health information and to inform you of our privacy practices.

Treatment at Northeast Spine & Wellness Center is provided in an open room where other patients are also being treated. Other persons in the office may overhear some of your health information during the course of your treatment. Should you need to speak with your health care provider in private, the doctor or therapist will provide a private room for these conversations. You may also request a private room should you need to discuss financial matters with a billing professional.

Your personal information and clinical records may be used for the following purposes:

- To provide you the best care and service possible, including for quality control and training purposes.
- To contact you with appointment reminders, health-related email messages, and birthday or holiday cards.
- To coordinate treatment with other health care professionals, including referring practitioners and primary care providers.
- To obtain payment; billing information and medical records may be provided to your insurance and to our billing service.

You have the following rights with regard to your health information:

- The right to review the above notice prior to signing this consent.
- The right to receive a copy of this notice of privacy practices for your records.
- The right to request restrictions as to how your personal or contact information may be used. Requests must be in writing.
- The right to request copies of your medical records. There may be a reasonable fee for photocopying and postage.
- The right to ask us, in writing, to amend your medical records if you feel the information is incomplete or inaccurate.
- The right to file a written complaint with our office or with the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be penalized or discriminated against for filing a complaint.

I have reviewed the notice of privacy practices provided to me by Northeast Spine & Wellness Center and grant permission for ASWC to use and disclose my protected health information in accordance with the conditions listed above.

Patient or Parent/Guardian's Signature:	Date

May we include you on our email list? ☐ YES ☐ NO *(You will be included unless you opt out.)*

FINANCIAL CONSENT

To all Patients,

Please acknowledge that your health insurance may issue checks to your home for services rendered by Northeast Spine & Wellness Center, LLC.

It is your responsibility to bring in the EOBs (Explanation of Benefits) and signed checks to our office in a timely manner. These checks are our form of payment.

Thank you for your cooperation.

By signing this notice, you understand and agree to this policy.

Print Patient Name:		Date:	
Patient Signature:		Date:	
Witness Signature Date		Date:	

North East Spine & Wellness Center

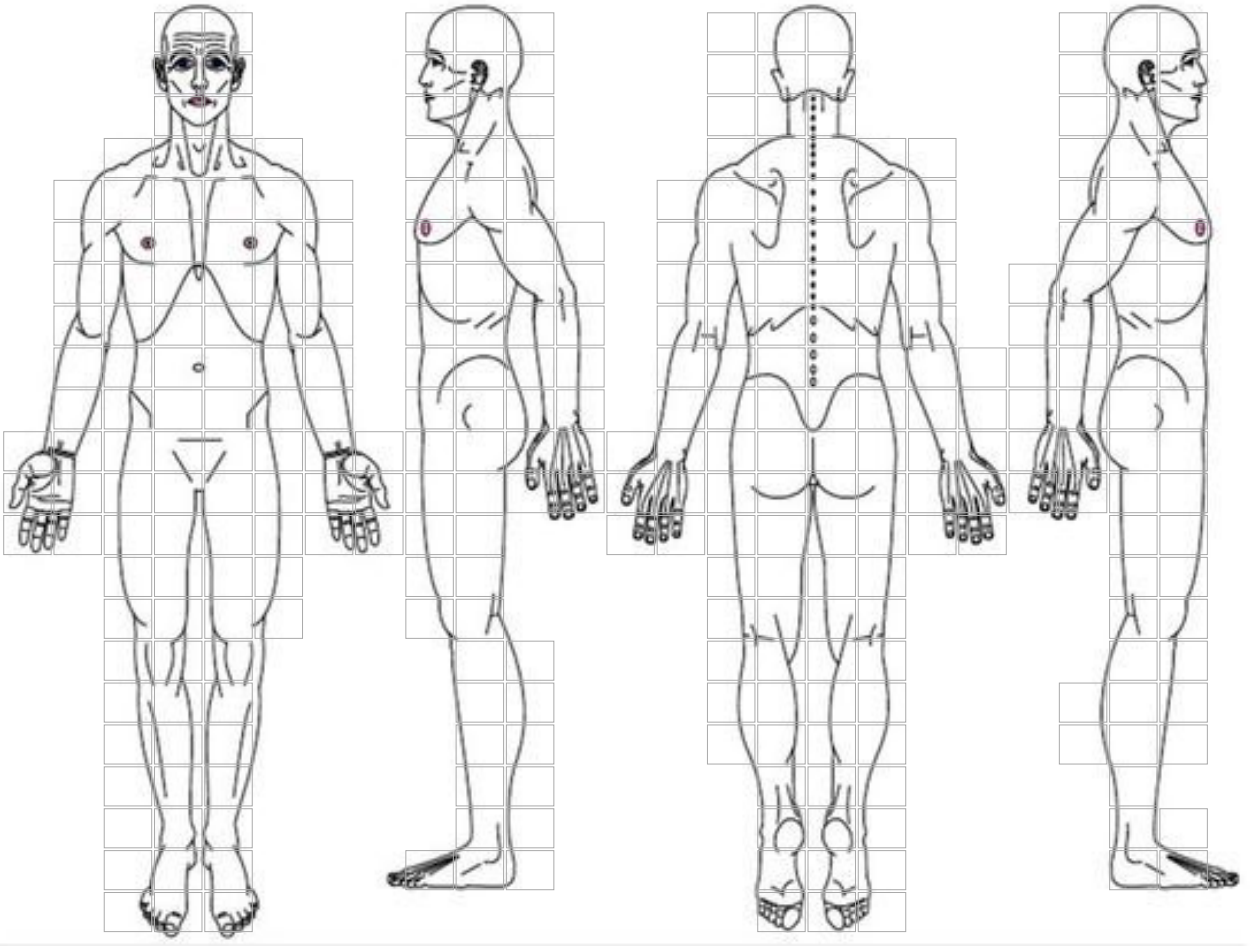
Date:		Name:	

1- PAIN SCALE: (Circle the number that represents your level of pain)

☐ NO PAIN ☐ UNBEARABLE

A. When your pain is at its worse?	0	1	2	3	4	5	6	7	8	9	10
B. When your pain is at its least?	0	1	2	3	4	5	6	7	8	9	10
C. Your present level of pain?	0	1	2	3	4	5	6	7	8	9	10

2- Please indicate location(s) of your pain and on diagrams below:



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