Brooklyn Spine Center

Patient Information

First Name:_____ MI: ___ Last Name: _____

Street: _____ Apt: _____

City:_____ State: _____ Zip: _____

Social Sec #: _____ Marital Status: S M P W D Spouse:_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

Language: ☐ English ☐ Spanish ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German
☐ Russian ☐ Other_____

Race: ☐ White ☐ American Indian or Alaska ☐ Native Asian ☐ Native Hawaiian/Other Pacific Islander
☐ Black or African American ☐ Hispanic or Latino ☐ Decline to Answer

Country of Origin_____ Years in USA_____

DOB: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Carrier: _____

Please check your contact preference: ☐ Cell ☐ Home ☐ Work ☐ Text ☐ Email ☐ Postal Mail

Email: _____

Occupation: _____ Employer: _____ How many yrs?_____

Employer Address: _____

Primary Physician: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone #: _____

Insurance Information

We will make a copy of your insurance card/s. However, please complete the following information.

Are you the policy holder? ☐ Y ☐ N If no, who is the policy holder? ☐ Spouse ☐ Parent ☐ Employer ☐ Other

Insurance Company: _____ ID#: _____ Company Phone: _____

Policy Holder's First Name: _____ M.I.: _____ Last Name: _____

Policy Holder's DOB: _____ Policy Holder's SS#: _____

Policy Holder's Employer: _____

Do you have secondary insurance coverage? ☐ Y ☐ N If yes, please complete the following:

Policy Holder's First Name: _____ M.I.: _____ Last Name: _____

Policy Holder's DOB: _____ Policy Holder's SS#: _____

Patient History

SUBJECTIVE
Reason for visit: _____

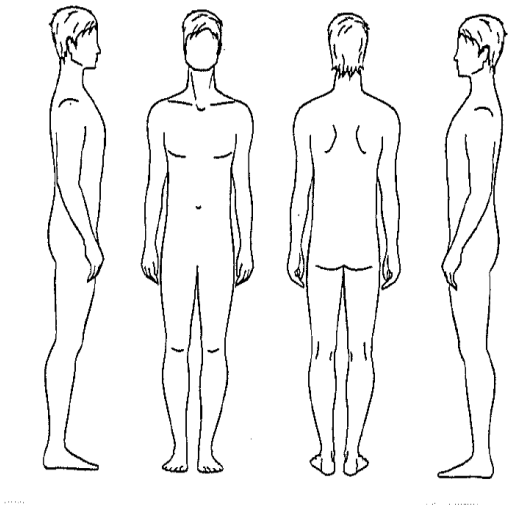
Describe Onset: ☐ Acute ☐ Chronic ☐ Gradual

Are you aware of what caused this problem? ☐ Accident ☐ Auto Accident ☐ Slept Wrong ☐ Slipped and Fell
☐ Lifted Heavy Boxes ☐ Moving Objects ☐ Other _____

Is the condition progressively getting worse: ☐ Yes ☐ No

Primary Area of Concern: _____

Indicate on the drawing where you have pain, tingling or numbness and degree of pain 1-10 with 1 (least) 10 (worst)



CHANGE IN CONDITION
How long have you had this problem? _____

Prior Back Pain: ☐ Y ☐ N If yes, when? _____ Side: ☐ Left ☐ Right ☐ Bilateral (Both)

Pain Quality: ☐ Achy ☐ Burning ☐ Dull ☐ Sharp ☐ Stiff ☐ Numbness ☐ Tingling

How often does the pain occur? ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional

Weakness: Location_____ Numbness: Location: _____

Pain Radiates to: ☐ No Radiation ☐ Buttock (L/R) ☐ Thigh (L/R) ☐ Calf (L/R) ☐ Ankle/Foot (L/R)

Prior Neck Pain: ☐ Y ☐ N If yes, when? _____ Side: ☐ Left ☐ Right ☐ Bilateral (Both)

Pain Quality: ☐ Achy ☐ Burning ☐ Dull ☐ Sharp ☐ Stiff ☐ Numbness ☐ Tingling

How often does the pain occur? ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional

Weakness: Location_____ Numbness: Location: _____

Pain Radiates to: ☐ No Radiation ☐ Posterior Head (L/R) ☐ Shoulder (L/R) ☐ Trapezius (L/R)
☐ Elbow (L/R) ☐ Hand (L/R) ☐ Fingers (L/R—Digits 1 2 3 4 5)

Is there a time of the day it is at its worst: ☐ No Change ☐ Morning ☐ As Day Progresses ☐ Afternoon ☐ Night

What activities/movements are guaranteed to make it worse? ☐ Nothing ☐ Walking ☐ Working on Computer
☐ Bending ☐ Resting ☐ Working ☐ Lifting ☐ Sitting ☐ Sleep ☐ Movement ☐ Driving

Describe the problem at its worst: _____

How has your life changed since you have had this problem? _____

What concerns you or worries you most about this problem? _____

_____

What activities are you limited in or guaranteed to make it worse? _____

_____

If you cannot find a solution to this problem, what do you think will happen to you? _____

_____

What makes it better? ☐ Nothing ☐ Cold ☐ Heat ☐ Massage ☐ Meds ☐ Chiropractic Care
☐ Movement ☐ Other _____

Please check all activities affected by the pain: ☐ Dressing ☐ Standing ☐ Lifting ☐ Exercise ☐ Driving
☐ Grooming ☐ Sitting or Standing ☐ Stair Climbing ☐ Computer Work ☐ In/Out of Bed

Headaches—if applicable:
Location: ☐ None ☐ Frontal ☐ Temporal ☐ Occipital

Time of Day: ☐ Morning ☐ As Day Progresses ☐ Afternoon ☐ Night

Rate Pain Scale: 1 2 3 4 5 6 7 8 9 10
Not Painful Very Painful

Duration: ☐ Hours ☐ Minutes How frequent does this occur? _____

What types of treatments have you received: _____

_____

Physical Therapy: When? _____ How many treatments? _____ How long? _____

Medications: When? _____ Type _____ How long? _____

Epidural: When? _____ How many injections? _____

How long? _____

Acupuncture: When? _____ How many treatments? _____

How long? _____

Surgery: When? _____ Type: _____

Yoga/Pilates/Massage: When? _____

Did any of these treatments work? If yes, which one(s) and for how long? _____

_____

Have you had an MRI? If yes, approximate date?_____ Location: _____

Do you have a Report CD

If your insurance company does not cover your treatment plan would you be willing to pay out of pocket to alleviate this condition: Yes No _____

Does your home or work life require any of the following: Lifting Carrying Pushing Pulling

Other Health Conditions

Present: _____

Past: _____

Surgeries: _____

Medications: _____

Allergies: _____

Nutrients: _____

Family: _____

Pregnancies: _____

Exercise Type: _____ How often: _____

Children: _____ Ages: _____ # Children at Home: _____

Grandchildren: _____ Do they live locally? Yes No

The following questions will help us better understand the extent and history of the physical, chemical and emotional stressors in your life and help us assist you in moving more towards wellness.

On an average day how would you rate stress in your life: 1 2 3 4 5 6 7 8 9 10
Least Highest

Where in your body to you hold or carry your stress? _____

What tools have you used to try to reduce your stress? _____

Do you have any physical or emotional traumas in your past? ☐ Yes ☐ No

If yes, approximate date _____ Rate the Severity: 1 2 3 4 5 6 7 8 9 10
Not Severe Very Severe

Is there anything keeping you from sleeping well? _____

When was the last time you bounced out of bed in the morning? _____

How much younger would you feel if your physical, chemical and emotional stress was significantly reduced or neutralized?

_____

How would you rate your happiness on a scale of 1-10? 1 2 3 4 5 6 7 8 9 10
Not Happy Very Happy

What bad habits do you need to release? _____

What are your beliefs about the body's ability to heal and repair itself? _____

_____

What are your beliefs about how your thoughts influence your healing response? _____

_____

How much do you prioritize your health? _____

Are you willing to invest time, money and energy in taking better care of yourself at this time? ☐ Yes ☐ No

How often do you exercise? _____ Do you smoke? ☐ Y ☐ N Do you drink alcohol? ☐ Y ☐ N If yes, how often?

How many times a week do you eat red meat? _____ How would you rate your current food choices with 10 being Superb and 1 being Poor. _____

Do you view yourself as overweight? ☐ Yes ☐ No If yes, approximately how many pounds? _____

What is your current weight? _____ Ideal/Goal weight? _____

When was the last time you were at your ideal/goal weight? _____

Have you tried to lose weight in the past? ☐ Y ☐ N If yes, what did you do? _____

When did you try to lose weight? _____

What are your top two reasons why you want to lose weight? _____

On a scale of 1-10 with 10 meaning I am fully committed, I want to start now and 1 meaning, not right for me at this time, what is your current level of commitment? _____

Signature: _____ Date: _____

A s s i g n m e n t & R e l e a s e

I understand and agree that health and accident insurance policies are an agreement between an Insurance carrier and myself. Furthermore, I understand that this office will prepare any 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 doctors 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. I also understand that if I suspend or terminate my care and treatment, any fees or outstanding balances for services I have received will be immediately due and payable.

Patient's/Parent's/Guardian Signature: _____ Date: _____

Consent of Professional Services and Release of Information

I herby authorize and release the doctor and whomever he/she may designate as his/her assistants, to administer treatment, physical examination, x- ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

Patient's/Parent's/Guardian Signature: _____ Date: _____