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Jason Brown, DC
Alison Passante, DC

Date: / /

<i>PATIENT INFORMATION</i>	<i>INSURANCE INFORMATION</i>
Name:	Are you covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
Address:	Insurance Company:
	Subscriber Name:
Sex: <input type="checkbox"/> M <input type="checkbox"/> F Age: Date of Birth: / /	Relationship to patient: <i>(check below)</i>
<input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> widowed <input type="checkbox"/> separated <input type="checkbox"/> divorced <input type="checkbox"/> partnered	<input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> parent/guardian <input type="checkbox"/> other
Patient Social Security #:	Assignment & Release:
Occupation:	I certify that I have insurance coverage and assign directly to Brown Integrated Chiropractic, PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.
Employer:	
Employer phone:	
Employer Address:	
Who may we thank for referring you?	Signature:

CONTACT INFORMATION

	<i>EMERGENCY CONTACT:</i>
Home Phone:	Relationship:
Work Phone:	Home Phone:
Cell Phone:	Work Phone:
Preferred contact: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	Cell Phone:
E-mail:	

Reason for visit:	
When did it start?	How did it start?
Is your condition due to an accident? <input type="checkbox"/> No <input type="checkbox"/> Yes (if so, what type) <input type="checkbox"/> Work-related <input type="checkbox"/> Vehicle <input type="checkbox"/> Other:	
Rate your symptoms (0-10):	Please describe your condition:
Is your condition getting worse: <input type="checkbox"/> No <input type="checkbox"/> Yes	Is it constant or does it come and go? <input type="checkbox"/> constant <input type="checkbox"/> comes & goes <input type="checkbox"/> don't know
Does it interfere with your <input type="checkbox"/> work <input type="checkbox"/> sleep <input type="checkbox"/> daily activities <input type="checkbox"/> sports/recreation <input type="checkbox"/> other:	
Do you experience pain with: <input type="checkbox"/> standing <input type="checkbox"/> walking <input type="checkbox"/> sitting <input type="checkbox"/> bending <input type="checkbox"/> lying down <input type="checkbox"/> lifting <input type="checkbox"/> sports <input type="checkbox"/> self-care	
What treatments have you already had for this condition <input type="checkbox"/> medical <input type="checkbox"/> physical therapy <input type="checkbox"/> surgical <input type="checkbox"/> x-ray/MRI <input type="checkbox"/> other <input type="checkbox"/> none	
With whom?	



Health History- *(Please read the list and check any items that apply to you)*

Previously Diagnosed or Current Conditions		
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Anemia	<input type="checkbox"/> Herniated disc / degenerated disc	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Arthritis	<input type="checkbox"/> High blood cholesterol	<input type="checkbox"/> Tumors
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> High blood pressure	Others: <i>(please list)</i>
<input type="checkbox"/> Cancer	<input type="checkbox"/> Multiple sclerosis	
<input type="checkbox"/> Chemical dependency	<input type="checkbox"/> Osteoporosis / Osteopenia	
<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> Pinched nerve	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Polio	
<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Prostate problems	
<input type="checkbox"/> Headaches	<input type="checkbox"/> Rheumatoid arthritis	
Height: feet inches	Weight: pounds	
Please list any prior surgeries or significant injuries <i>(include date)</i>		

Family History *(Does anyone in your family have any of the following)*

<input type="checkbox"/> Autoimmune disorders	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Seizure disorders

MEDICATIONS	ALLERGIES	VITAMINS/SUPPLEMENTS/HERBS

Social History

My work duties include: <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Light labor <input type="checkbox"/> Heavy Labor <input type="checkbox"/> Other
My exercise level is: <input type="checkbox"/> Intense <input type="checkbox"/> Moderate <input type="checkbox"/> Light <input type="checkbox"/> Minimal <i>List Activities:</i>
My habits include: <input type="checkbox"/> Smoking/Tobacco use _____ packs/day <input type="checkbox"/> Alcohol consumption _____ drinks/week <input type="checkbox"/> Caffeine (coffee, soda, tea) _____ cups/day <input type="checkbox"/> High stress level:

Primary Care Provider:

Name: _____	Date last seen: _____
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Patient signature

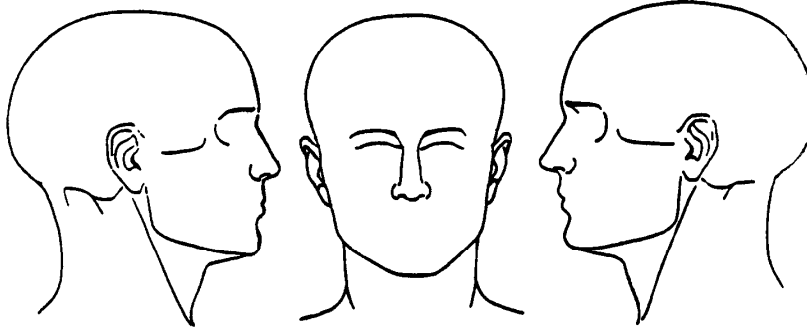
Date

Patient Name: _____
(please print)

Date: _____

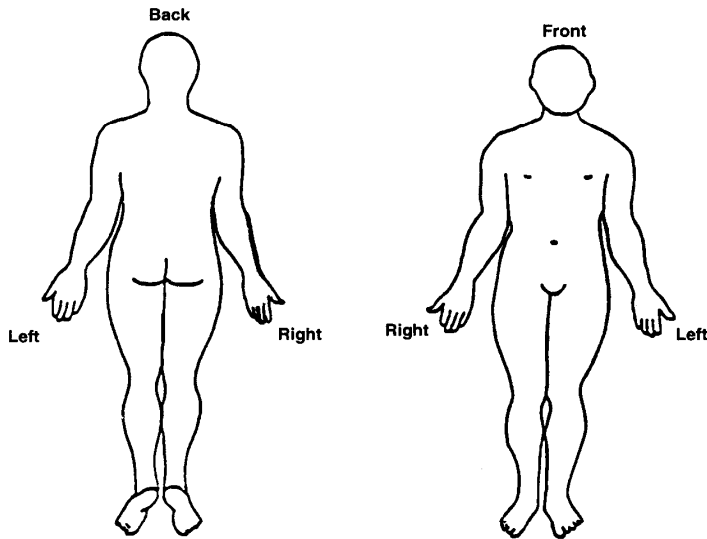
Please draw the location of your symptoms on the body diagram below and mark your current level of pain on the line at the bottom of the diagram.

Ache	Burning	Numbness	Pins and Needles	Stabbing	Other
^^^ ^^	=====	oooooo	//////	xxxxx
^^^	=====	oooo	////	xxx



No Pain |-----| Worst Pain Possible

Please make a slash through this line as to the level of your pain.



No Pain |-----| Worst Pain Possible

Please make a slash through this line as to the level of your pain.

Patient Signature: _____

Date: _____



CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME _____
DATE OF BIRTH _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. **This information is kept private except uses involved in your healthcare.**

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and prior health information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that:

- I have the right to object to the use of my health information for directory purposes.
- I have access to a copy of the "Notice of Patient Privacy Rights" and they are available in the office.
- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations, and that the organization is not required to agree to the restrictions requested.
- I have the right to revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.
- I have the right to request a copy of my records. I understand this requires 48 hours notice.
- I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by recipient and that this information will no longer be subject to protection as protected health information.

I request the following additional restrictions to the use or disclosure of my health information:

I authorize Brown Integrated Chiropractic, PLLC to speak with the following people regarding my healthcare:

With my consent, Brown Integrated Chiropractic, PLLC, may call my home or other designated location, and leave a voice message in reference to any items that assist the practice in carrying out treatment, payment and health care operation, such as appointment reminders, insurance items and information pertaining to my clinical care.

With my consent Brown Integrated Chiropractic, PLLC may send a narrative to my primary care doctor explaining my evaluation and treatment plan.

PATIENT:

X _____

Signature of patient/ Legal Representative

_____ Date