



Brown Integrated Chiropractic

Jason Brown, D.C.
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1542 Columbia Turnpike
Schodack, NY 12033
Phone: (518) 477-4405

REGISTRATION & HISTORY

Date: _____

PATIENT INFORMATION

Name: _____ Nickname: _____
 Address: _____ City _____ State _____ Zip _____
 Sex: M F Age: _____ Birth date ___/___/___ single married widowed separated divorced partnered
 Patient Social Security Number _____ - _____ - _____
 Occupation _____ Employer _____
 Employer Phone (_____) _____ Address _____
 Primary Care Provider: _____ Date of last visit: _____
 Whom may we thank for referring you? _____

PHONE NUMBERS

Home: _____
 Work: _____
 Cell: _____
 Preferred contact: Home Work Cell
 Email: _____

EMERGENCY CONTACT

Name: _____
 Relationship: _____
 Home: _____
 Work: _____
 Cell: _____

INSURANCE INFORMATION

Do you plan to use health insurance for your care? yes no *(if yes, please complete the rest of this section)*
 Insurance Company: _____
 Relationship to insured: self spouse parent/guardian other
Assignment & Release:
 I certify that I have insurance coverage and assign directly to Brown Integrated Chiropractic, PLLC all insurance benefits, if any, for Services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize use of this signature on all insurance submissions.
SIGNATURE: _____

INJURY/CONDITION

Will your visit today be for: Injury/ Health Condition / Pain Wellness/Sports Performance
 Was this injury related to an accident? yes no If yes, was it work-related auto other

PATIENT CONDITION

Reason for Visit: _____

When did it start? _____ How did it start? _____

Please describe your condition: _____

Rate your symptoms (0=worst, 10=best) _____ /10 With time is your condition? getting better getting worse not changing

Are your symptoms constant or do they come & go? constant comes & goes

What makes your symptoms worse? standing sitting walking bending/lifting lying down sports/exercise self-care

What makes your symptoms better? _____

What treatments have you already had for this condition: none medical chiropractic surgical physical therapy massage acupuncture other (please describe) _____

Have you had any recent imaging of the area? x-ray MRI CT scan bone density/DEXA other _____

Does your condition interfere with your activities (work duties, daily life, social activities, and/or recreation)? yes no

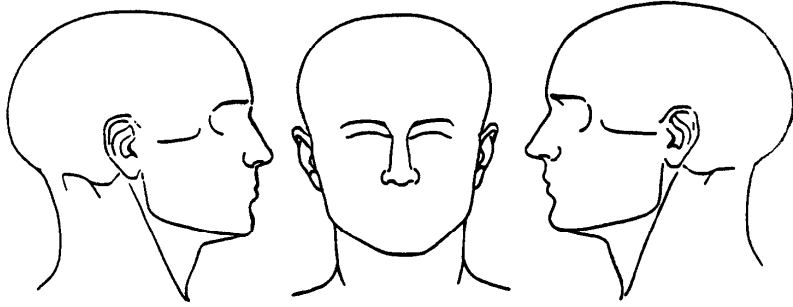
If yes, please list 3 activities that you have difficulty with:

1. _____

2. _____

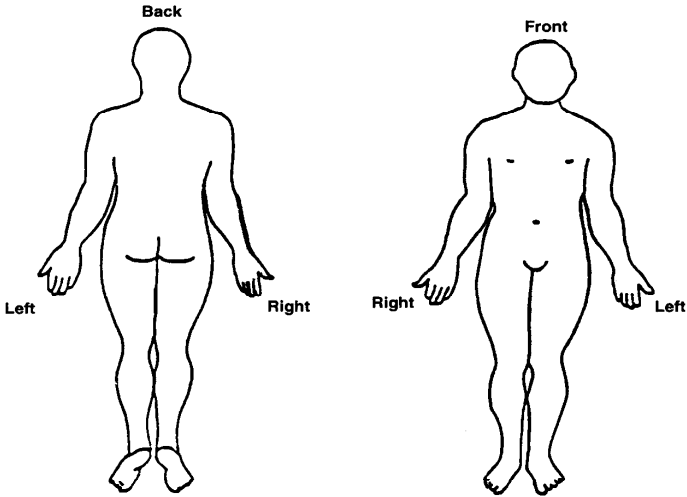
3. _____

Ache ^^^^^^ ^^^^	Burning =====	Numbness o o o o o o o o o o	Pins and Needles	Stabbing //////// ////	Other x x x x x x x x
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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.

HEALTH HISTORY		
Have you had any of the following:	High Blood Pressure <input type="checkbox"/> yes <input type="checkbox"/> no	WOMEN ONLY:
AIDS/HIV <input type="checkbox"/> yes <input type="checkbox"/> no	High cholesterol <input type="checkbox"/> yes <input type="checkbox"/> no	Are you pregnant? <input type="checkbox"/> yes <input type="checkbox"/> no
Anemia <input type="checkbox"/> yes <input type="checkbox"/> no	Multiple Sclerosis <input type="checkbox"/> yes <input type="checkbox"/> no	Due date: _____
Anxiety <input type="checkbox"/> yes <input type="checkbox"/> no	Osteopenia <input type="checkbox"/> yes <input type="checkbox"/> no	Abnormal/painful <input type="checkbox"/> yes <input type="checkbox"/> no
Arthritis <input type="checkbox"/> yes <input type="checkbox"/> no	Osteoporosis <input type="checkbox"/> yes <input type="checkbox"/> no	menstrual cycle
Asthma <input type="checkbox"/> yes <input type="checkbox"/> no	Pacemaker <input type="checkbox"/> yes <input type="checkbox"/> no	Miscarriage <input type="checkbox"/> yes <input type="checkbox"/> no
Bleeding disorders <input type="checkbox"/> yes <input type="checkbox"/> no	Parkinson's disease <input type="checkbox"/> yes <input type="checkbox"/> no	Menopause <input type="checkbox"/> yes <input type="checkbox"/> no
Cancer <input type="checkbox"/> yes <input type="checkbox"/> no	Pinched nerve <input type="checkbox"/> yes <input type="checkbox"/> no	PRIOR SURGERIES _____ Date _____
Chemical dependency <input type="checkbox"/> yes <input type="checkbox"/> no	Polio <input type="checkbox"/> yes <input type="checkbox"/> no	
Depression <input type="checkbox"/> yes <input type="checkbox"/> no	Prostate problem <input type="checkbox"/> yes <input type="checkbox"/> no	
Diabetes <input type="checkbox"/> yes <input type="checkbox"/> no	Prosthesis <input type="checkbox"/> yes <input type="checkbox"/> no	
Epilepsy/Seizures <input type="checkbox"/> yes <input type="checkbox"/> no	Psychiatric care <input type="checkbox"/> yes <input type="checkbox"/> no	
Fractures <input type="checkbox"/> yes <input type="checkbox"/> no	Rheumatoid arthritis <input type="checkbox"/> yes <input type="checkbox"/> no	
Headaches <input type="checkbox"/> yes <input type="checkbox"/> no	Stroke <input type="checkbox"/> yes <input type="checkbox"/> no	
Heart disease <input type="checkbox"/> yes <input type="checkbox"/> no	Suicide attempt <input type="checkbox"/> yes <input type="checkbox"/> no	
Hepatitis <input type="checkbox"/> yes <input type="checkbox"/> no	Thyroid problems <input type="checkbox"/> yes <input type="checkbox"/> no	
Hernia <input type="checkbox"/> yes <input type="checkbox"/> no	Tumors <input type="checkbox"/> yes <input type="checkbox"/> no	
Herniated disk <input type="checkbox"/> yes <input type="checkbox"/> no	Ulcers <input type="checkbox"/> yes <input type="checkbox"/> no	
Height: feet inches	Weight: pounds	

Additional Info:

MEDICATIONS	ALLERGIES	VITAMINS/SUPPLEMENTS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY (Does anyone in your family have any of the following?)			
<input type="checkbox"/> Arthritis-Rheumatism	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Osteoporosis/Osteopenia	OTHER: (Please list)
<input type="checkbox"/> Autoimmune disorders	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke	
<input type="checkbox"/> Back/Spine Condition	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Thyroid disorder	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Mental Illness		

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 <input type="checkbox"/> None
My current exercise includes: (list activities)
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 <input type="checkbox"/> Recreational drug use

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 mail to my home any items that assist the practice in carrying out the above listed operations.

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

Witness Signature



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INFORMED CONSENT

I understand and am informed that, as in all health care, in the practice of chiropractic there is a small inherent risk of injury which includes but is not limited to, muscle strains, sprains, fractures, dislocation, intervertebral disc injury, and cardiovascular accident. I understand that my doctor will not be able to anticipate all potential complications, but will rely on clinical expertise and judgment to determine the correct course of treatment, which will be in my best interests considering all known facts. I understand that results are not guaranteed and that I have the opportunity to discuss the purposes and risks associated with all recommended evaluation and treatment procedures at any time.

I have read and understand the preceding statements and hereby consent to voluntarily participate in orthopedic, neurologic and physical performance testing, as well as manipulative, and exercise/rehabilitation therapies as deemed appropriate. If at any time, I have further questions or decide not to continue to consent in treatment, I understand I have that right and it is my duty to notify my doctor.

_____	_____	_____
PRINT PATIENT NAME	SIGNATURE	DATE

If patient is a minor:

_____	_____	_____
PRINT PARENT/GUARDIAN NAME	SIGNATURE	DATE



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Chiropractic**

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Alison Brown, D.C.**

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AUTHORIZATION FOR RELEASE OF CASE RECORDS

I, _____ hereby authorize any physician, hospital, or other health care provider to release to Brown Integrated Chiropractic, PLLC any information regarding my medical history, diagnostic testing, treatment, exam results, or diagnosis for the purpose of coordinating my healthcare.

Date of birth: _____

SIGNATURE

DATE