Long Island Chiropractic & Wellness Center 2296 Hempstead Turnpike East Meadow, NY 11554

PATIENT REGISTRATION: Today's Date_____

Last Name_____First Name_____

Address_____Home Phone_____

City,State,Zip_____Work Phone_____

Email Address_____Cell Phone_____

SS#_____ Date of Birth_____Age_____ Sex ( ) Male ( ) Female

Married ( ) Yes ( ) No Spouse's Name _____ Single ( ) Yes ( ) No Other ( ) Yes ( ) No

Are you currently Working ( ) Yes ( ) No Retired ( ) Yes ( ) No Last Date worked?_____

Employer_____Occupation_____

Address_____City_____State_____Zip_____

Who is your Primary Care Physician_____Phone_____

Physician Address_____

HEALTH INSURANCE INFORMATION

Primary Insurance Carrier_____Phone_____

Policy #_____Group #_____

Address_____

Patient Relationship to Insured ( ) Self ( ) Spouse ( ) Child ( ) Other_____

Secondary Insurance Carrier _____Phone_____

Policy #_____Address_____

IF PATIENT IS A MINOR OR YOU ARE COVERED UNDER ANOTHER PERSON'S INSURANCE:

Name of Insured_____Date of Birth_____SS#_____

Address_____City_____State_____Zip_____

Employer_____Office Phone_____\

Chief Complaint: What is a reason for this visit_____

_____/_____

Last Name First Name Date

Did your bring films/Discs? X-Ray ☐ Y ☐ N MRI ☐ Y ☐ N CD/DVD ☐ Y ☐ N

Location: What is the location of your injury? *Check all that apply*

☐ Spine/Back ☐ Neck ☐R Shoulder ☐ L Shoulder ☐ R Arm ☐ L Arm ☐ Low back ☐ Hips ☐ L Leg ☐ R Leg

☐ Other area_____

State of NY – Worker's Compensation: If this injury was **WORK RELATED,** Please answer all of the questions below
Check the ONE box which best describes how your problem started and answer the questions below.
☐ No Injury or Injury was ☐Gradual ☐ Sudden
☐ INJURY AT WORK From a ☐ lift ☐ twist ☐ fall ☐ bend ☐ pull Date_____Time _____Where_____
Have you missed time from work? ☐ Y ☐ N If yes, how much?_____days/weeks/months/years
When is your last date worked? _____
If you are NOT working is your goal to return to work? ☐ Y ☐ N
Current work status? ☐ Regular ☐ Light Duty ☐ Not working due to this injury ☐ Disabled ☐ Retired ☐ Student
Are you currently receiving or plan to apply for: Disability: ☐ Y ☐ N Worker's Comp: ☐ Y ☐ N Unemployment: ☐ Y ☐ N
Was your injury reported to your employer? ☐ Y ☐ N If so, Who did you report it to?_____
Where you hospitalized for this injury? ☐ Y ☐ N **What is your Job Title/Description:** _____
On date of injury what were your work activities?_____
_____

Please write specific details of your problem: _____

_____

Are you being treated by another physician for this condition/injury? ☐ Y ☐ N If yes? Dr_____

What tests/scans have you had for this problem ☐ X-rays ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Nerve Test (EMG

If yes, what location_____ Dominant hand: ☐ L ☐ R ☐ Ambidextrous (both)

If this injury was due to a MOTOR VEHICLE ACCIDENT. Please answer the questions below
Were you wearing a seat belt at the time of the accident? ☐ Y ☐ N Airbag deploy ☐ Y ☐ N

Your car: ☐ Hit another car ☐ Was hit in the ☐ Right ☐ Left ☐ Rear ☐ Front

Type of Accident ☐ Head on Collision ☐ Broad side collision ☐ Front impact ☐ T Collision ☐ You were pedestrian

Date of Accident: _____ If applicable what Hospital did you go to?_____

What type of pain do you have?
☐ Burning ☐ Dull/Aching ☐ Radiating ☐ Sharp ☐ Tightness ☐ Tingling ☐ Tightness

What is your level of pain when active? (1-10, 1 being the least) _____

What is your level of pain at rest? (1-10, 1 being the least) _____

_____/_____
Last Name First Name Date

Duration: How long have you had your pain? _____ Days/months/years

Have you had a problem like this before? ☐ Y ☐ N Date original problem started:_____

When do you have the worst pain? ☐ Morning ☐ Afternoon ☐ Night ☐with activity

Does your pain affect your ability to sleep? ☐ Y ☐ N

Does your pain get better with (Please circle) Warmth or Cold **Does it get worse with:** Warmth/Cold/Dampness

What makes your symptoms/pain worse? ☐Stretching ☐ Sitting ☐ Standing ☐ Twisting ☐ Walking ☐ Bending ☐ Squatting ☐ Kneeling ☐ Warmth ☐ Cold ☐ Lifting ☐ Exercise ☐ Stairs ☐ Lying in bed ☐ Coughing ☐ Other:_____

Which makes your symptoms/pain better? ☐ Rest ☐ Rx Meds ☐ Elevation ☐ Ice ☐Heat ☐ Massage
What are you treating your pain with? _____

Have you had any of these treatments? ☐ Injections ☐ Brace/s ☐ Physical Therapy

Do you have any of the following? Check any that apply. ☐ none ☐ Blurred Vision ☐ Depression ☐ Irritability ☐ Tingling ☐ Nausea ☐ Ringing in ears ☐ Stiffness ☐ Headaches ☐ Weakness ☐ Aches ☐ Burning ☐ Difficulty walking ☐ Sleep disturbance ☐ Dizziness ☐ Ecchymosis ☐ Chronic fatigue ☐ Fever ☐ Heartburn ☐ Joint Stiffness ☐ Muscle Spasm ☐ Numbness ☐ Pale bluish skin ☐ Pins and Needles ☐ Shortness of breath ☐ Sweating ☐ Bruises

REVIEW OF SYMPTOMS **Have you had any problems related to the following symptoms** ***Circle all that apply***

Constitutional Systems				
Eyes	Blurred	Double Vision	Vision Change	NONE
Ear/Nose/Throat	Earache	Sore Throat	Sinus Congestion	NONE
Cardiovascular	Chest pain	Shortness of Breath	Palpatations	NONE
Respiratory	Chronic Cough	Wheezes	Asthma	NONE
Gastrointestinal	Abdominal Pain	Nausea	Bowel Habit Changes	NONE
Gentourinary	Frequent Urination	Urine Retention	Kidney Problems	NONE
Musculoskeletal	Neck Pain	Back Pain	Joint Pain	NONE
Skin	Rash	Skin Discolor	Persistent Itch	NONE
Neurologic	Stroke	Weakness	Vertigo	NONE
Psychiatric	Anxiety	Depression	Sleep Disorder	NONE
Endocrine	Thirst Increase	Sweats	Thyroid Disease	NONE
Hematologic	Swollen Glands	Blood Clotting	Anemia	NONE
Allergic	Hay Fever			NONE

_____/_____

Last Name First Name Date

What is your height and weight? Height:____Ft _____Inches **Weight:** _____ lbs_____oz

Do you take anti coagulants (blood thinners) ?_____

Please list any surgeries you have had:_____
_____

CURRENT PERSONAL ILLNESSES: ***check all that apply***
□ None
□ Diabetes □ Heart Disease □ High blood pressure □ Elevated cholesterol □ Lung disease □ Thyroid disease □ Ulcers
□ Cancer □ Pacemaker □ Kidney disease □ Liver disease □ Seizures □ Psychiatric disorders □ HIV
□ Other _____

FAMILY HISTORY

Is there a family history of medical conditions? □ Yes □ No

If yes, please list _____

Which family member _____

SOCIAL HISTORY

Marital Status: □ Single □ Married □ Divorced/Separated □ Widowed

Smoking Status: □ Never Smoked □ Former Smoker □ Smoke Every day □ Sometimes Smoke how many packs a day?___

Alcohol Usage: □ Non-Drinker □ Social Drinker □ Alcoholic **Have you been treated for alcohol addiction?** □ Y □ N

Drug Usage: □ Yes □ No If yes : □ Marijuana □ Cocaine □ Amphetamines □ Other_____

Have you been treated for drug addiction? □ Yes □ No

MEDICATIONS: Pleas list current medications and doses
_____
_____

ALLERGIES: Do you have any allergies? □ Yes □ No

Please List any allergies _____
_____

_____/_____
Last Name First Name Date

CONSENT INFORMATION

CONSENT TO TREAT

This information I have given this office is complete and true to the best of my knowledge. I authorize Dr. Bachenheimer and Staff of Long Island Chiropractic & Wellness Center, to administer such procedures and they deem necessary. They implied no guarantee of cure.

Patients Initials _____ Date_____

CONSENT TO TREAT A MINOR CHILD

The information I have given this office pertaining to _____ is true and complete to the best of my knowledge. I authorize the doctors and staff of Long Island Chiropractic & Wellness Center to administer such procedures and treatment as they deem necessary to my child/ward in my legal custody. The Doctor has implied no guarantee of cure.

Parent/Guardian initials_____ Date_____

FOR WOMEN ONLY

Dr. Ronda Bachenheimer has advised me that x-rays can be hazardous to an unborn child. At the time and the best of my knowledge, I am not pregnant. I consent to having x-rays taken.

Patients Initials _____ Date_____

PAYMENT AGREEMENT/ASSIGNMENT OF BENEFITS

I understand and agree that health and accident insurance 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 making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse the issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are changed 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 for professional services rendered me will be immediately due and payable.

A photocopy of this assignment shall be considered as effective and valid as the original.

I authorize the release of information pertinent to my case to my insurance company, claims adjuster or attorney involved in this case.

I hearby instruct and direct my insurance company to directly reimburse my provider for charges incurred on my behalf. Please remit payment directly to:

Dr. Ronda Bachenheimer
2296 Hempstead Turnpike
East Meadow, NY 11554

Patient's signature_____ Date_____

Guardian's signature_____Date_____

HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT

I, _____, acknowledge that I have been provided with a copy of Long Island Chiropractic and Wellness Center's HIPAA Privacy Notice. I would like to authorize the following parties to have access to my protected health information_____

Signature_____Date_____