Health Care Chiropractic Centre
CONFIDENTIAL
HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is conf dential. We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?
☐ No ☐ Yes When?

Whom may we thank for referring you?

If so, whom?

Gender
☐ Male ☐ Female

Your Last Name

Your Social Security Number

Your First Name | Your Middle Name (or Initial) | Birth Date (MM/DD/YYYY)

Marital Status
☐ Single ☐ Married ☐ Divorced
☐ Widowed ☐ Separated

Address

City | State/Province | ZIP/Postal Code | Home Phone | Spouse's Name

Email Address | Cell Phone | Child's Name and Age

Emergency Contact | Phone | Child's Name and Age

Your Occupation | Child's Name and Age

Your Employer

May we contact you at work?
☐ Yes ☐ No

Address

City | State/Province | ZIP/Postal Code | Work Phone

Dr. Steven B. Goldstein D.C. P.C.
215 Atlantic Avenue Suite A
Lynbrook, NY 11563
(516) 887-1001

1. **The symptom(s) that have prompted me to seek care today include:** _____

_____

Patient name _____

2. **And are the result of (darken circle):** ☐ An accident or injury
☐ Work ☐ Auto ☐ Other _____
☐ A worsening long-term problem
☐ An interest in: ☐ Wellness ☐ Other _____

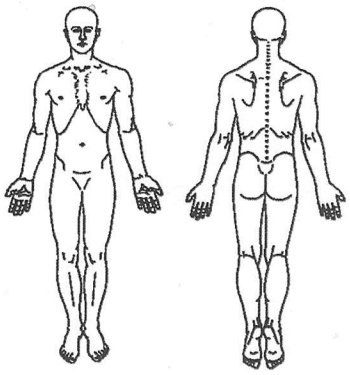
3. **Onset** (When did you f rst notice your current symptoms?)
_____

4. **Intensity** (How extreme are your current symptoms?)
0 ☐☐☐☐☐☐☐☐☐☐ 10
Absent Uncomfortable Agonizing

5. **Duration and Timing** (When did it start and how often do you feel it?)
☐ Constant ☐ Comes and goes. How Often? _____
_____

6. **Quality of symptoms** (What does it feel like?)
☐ Numbness
☐ Tingling
☐ Stiffness
☐ Dull
☐ Aching
☐ Cramps
☐ Nagging
☐ Sharp
☐ Burning
☐ Shooting
☐ Throbbing
☐ Stabbing
☐ Other _____

7. **Location** (Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



8. **Radiation** (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)
_____

9. **Aggravating or relieving factors** (What makes it better or worse, such as time of day, movements, certain activities, etc.)
What tends to worsen the problem? _____
What tends to lessen the problem? _____

10. **Prior interventions** (What have you done to relieve the symptoms?)
☐ Prescription medication ☐ Surgery ☐ Ice
☐ Over-the-counter drugs ☐ Acupuncture ☐ Heat
☐ Homeopathic remedies ☐ Chiropractic Other _____
☐ Physical therapy ☐ Massage _____

11. What else should Dr. Goldstein know about your current condition?

_____

12. **How does your current condition interfere with your:**

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

13. **Review of Systems**
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Osteoporosis	☐	☐	Arthritis	☐	☐	Scoliosis	☐	☐	Neck pain	☐	☐	Back problems	☐	☐	Hip disorders
☐	☐	Knee injuries	☐	☐	Foot/ankle pain	☐	☐	Shoulder problems	☐	☐	Elbow/wrist pain	☐	☐	TMJ issues	☐	☐	Poor posture

NONE ○ Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Anxiety	☐	☐	Depression	☐	☐	Headache	☐	☐	Dizziness	☐	☐	Pins and needles	☐	☐	Numbness

NONE ○ Initials ____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	High blood pressure	☐	☐	Low blood pressure	☐	☐	High cholesterol	☐	☐	Poor circulation	☐	☐	Angina	☐	☐	Excessive bruising

NONE ○ Initials ____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Asthma	☐	☐	Apnea	☐	☐	Emphysema	☐	☐	Hay fever	☐	☐	Shortness of breath	☐	☐	Pneumonia

NONE ○ Initials ____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Anorexia/bulimia	☐	☐	Ulcer	☐	☐	Food sensitivities	☐	☐	Heartburn	☐	☐	Constipation	☐	☐	Diarrhea

NONE ○ Initials ____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Blurred vision	☐	☐	Ringing in ears	☐	☐	Hearing loss	☐	☐	Chronic ear infection	☐	☐	Loss of smell	☐	☐	Loss of taste

NONE ○ Initials ____

g. Integumentary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Skin cancer	☐	☐	Psoriasis	☐	☐	Eczema	☐	☐	Acne	☐	☐	Hair loss	☐	☐	Rash

NONE ○ Initials ____

Consultation Notes

Doctor's Initials _____

(Continued from previous page)

h. Endocrine

Had Have ☐ ☐ Thyroid issues | Had Have ☐ ☐ Immune disorders | Had Have ☐ ☐ Hypoglycemia | Had Have ☐ ☐ Frequent infection | Had Have ☐ ☐ Swollen glands | Had Have ☐ ☐ Low energy | NONE ○ Initials ____

i. Genitourinary

Had Have ☐ ☐ Kidney stones | Had Have ☐ ☐ Infertility | Had Have ☐ ☐ Bedwetting | Had Have ☐ ☐ Prostate issues | Had Have ☐ ☐ Erectile dysfunction | Had Have ☐ ☐ PMS symptoms | NONE ○ Initials ____

j. Constitutional

Had Have ☐ ☐ Fainting | Had Have ☐ ☐ Low libido | Had Have ☐ ☐ Poor appetite | Had Have ☐ ☐ Fatigue | Had Have ☐ ☐ Sudden weight change | Had Have ☐ ☐ Weakness | NONE ○ Initials ____

Patient name

○ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
☐	☐	AIDS	☐	☐	Tuberculosis
☐	☐	Alcoholism	☐	☐	Typhoid fever
☐	☐	Allergies	☐	☐	Ulcer
☐	☐	Arteriosclerosis	☐	☐	Other: ____
☐	☐	Cancer			____
☐	☐	Chicken pox			____
☐	☐	Diabetes			____
☐	☐	Epilepsy			____
☐	☐	Glaucoma			____
☐	☐	Goiter			____
☐	☐	Gout			____
☐	☐	Heart disease			____
☐	☐	Hepatitis			
☐	☐	Malaria			
☐	☐	Measles			
☐	☐	Multiple Sclerosis			
☐	☐	Mumps			
☐	☐	Polio			
☐	☐	Rheumatic fever			
☐	☐	Scarlet fever			
☐	☐	Sexually transmitted disease			
☐	☐	Stroke			

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- ☐ Appendix removal
- ☐ Bypass surgery
- ☐ Cancer
- ☐ Cosmetic surgery
- ☐ Elective surgery: ____
- ☐ Eye surgery
- ☐ Hysterectomy
- ☐ Pacemaker
- ☐ Spine ____
- ☐ Tonsillectomy
- ☐ Vasectomy
- ☐ Other: ____

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
☐	☐	Acupuncture
☐	☐	Antibiotics
☐	☐	Birth control pills
☐	☐	Blood transfusions
☐	☐	Chemotherapy
☐	☐	Chiropractic care
☐	☐	Dialysis
☐	☐	Herbs
☐	☐	Homeopathy
☐	☐	Hormone replacement
☐	☐	Inhaler
☐	☐	Massage therapy
☐	☐	Physical therapy
☐	☐	Nutritional supplements: List: ____
☐	☐	Medications (prescription and over-the-counter): ____

17. Injuries

Have you ever...

- ☐ Had a fractured or broken bone
- ☐ Had a spine or nerve disorder
- ☐ Been knocked unconscious
- ☐ Been injured in an accident
- ☐ Used a crutch or other support
- ☐ Used neck or back bracing
- ☐ Received a tattoo
- ☐ Had a body piercing

Consultation Notes

18. Family History

FAMILY

Relative	Age (If living)	State of health Good	Poor	Illnesses	Age at death	Cause of death Natural	Illness
Mother	____	☐	☐	____	____	☐	☐
Father	____	☐	☐	____	____	☐	☐
Sister 1	____	☐	☐	____	____	☐	☐
Sister 2	____	☐	☐	____	____	☐	☐
Brother 1	____	☐	☐	____	____	☐	☐
Brother 2	____	☐	☐	____	____	☐	☐
____	____	☐	☐	____	____	☐	☐

19. Are there any other hereditary health issues that you know about? ____

20. Social History

SOCIAL

Alcohol use	☐ Daily ☐ Weekly	How much? ____	Prayer or meditation? ☐ Yes ☐ No
Coffee use	☐ Daily ☐ Weekly	How much? ____	Job pressure/stress? ☐ Yes ☐ No
Tobacco use	☐ Daily ☐ Weekly	How much? ____	Financial peace? ☐ Yes ☐ No
Exercising	☐ Daily ☐ Weekly	How much? ____	Vaccinated? ☐ Yes ☐ No
Pain relievers	☐ Daily ☐ Weekly	How much? ____	Mercury f llings? ☐ Yes ☐ No
Soft drinks	☐ Daily ☐ Weekly	How much? ____	Recreational drugs? ☐ Yes ☐ No
Water intake	☐ Daily ☐ Weekly	How much? ____	

Hobbies: ____

Doctor's Initials

21. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	☐	☐	☐	☐
Rising out of chair	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Lying down	☐	☐	☐	☐
Bending over	☐	☐	☐	☐
Climbing stairs	☐	☐	☐	☐
Using a computer	☐	☐	☐	☐
Getting in/out of car	☐	☐	☐	☐
Driving a car	☐	☐	☐	☐
Looking over shoulder	☐	☐	☐	☐
Caring for family	☐	☐	☐	☐

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	☐	☐	☐	☐
Household chores	☐	☐	☐	☐
Lifting objects	☐	☐	☐	☐
Reaching overhead	☐	☐	☐	☐
Showering or bathing	☐	☐	☐	☐
Dressing myself	☐	☐	☐	☐
Love life	☐	☐	☐	☐
Getting to sleep	☐	☐	☐	☐
Staying asleep	☐	☐	☐	☐
Concentrating	☐	☐	☐	☐
Exercising	☐	☐	☐	☐
Yard work	☐	☐	☐	☐

22. What is the major stressor in your life? _____

23. How much sleep do you average per night? _____ **Hours**

24. What is the type and approximate age of your mattress and pillow? _____

25. What is your preferred sleeping position? _____

26. Describe your typical eating habits: ☐ Skip breakfast ☐ Two meals a day ☐ Three meals a day ☐ Snacking between meals

27. What would be the most signif cant thing that you could do to improve your health? _____

28. In addition to the main reason for your visit today, what additional health goals do you have? _____

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** _____

Initials ____ **I grant permission to be called to conf rm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this off ce.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

If the patient is a minor child, print child's full name: _____

_____ Signature

_____ Date (MM/DD/YYYY)

Patient name _____

Consultation Notes

Doctor's Initials _____

Dr. Steven B. Goldstein, D.C., P.C.

Health Care Chiropractic Centre

215 Atlantic Avenue Suite A
Lynbrook, N.Y. 11563

OFFICE 516- 887-1001
FAX 516- 887-1004

NOTICE OF PRIVACY PRACTICES

1. **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.** This notice is provided in two layers: This first layer briefly summarizes how we handle your health information; the second layer is a full copy in greater detail of our privacy policies and procedures and is prominently posted in our waiting room, at our webpage, and copies of which are available and provided to you at our front desk.
2. **How we may use and disclose your health information.** We use health information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization before using or disclosing your health information. If you sign an authorization to disclose information you can later revoke it to stop any future uses and disclosures.
3. **Your rights.** In most cases, you have the right to look at or get a copy of your health information that we use to make decisions about you. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.
4. **Our legal duty.** We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in the notice, and seek your acknowledgment of receipt of this notice. We may change our privacy policies any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy policies, contact the person listed above.
5. **Privacy complaints.** If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

Acknowledgment of receipt of Notice of Privacy Practices: Please sign and print your name and provide the date below to acknowledge that you have received both layers of this Notice of Privacy Practices. Then return this acknowledgement of receipt to the receptionist or to the address above.

Signature: _____ Name: _____

Patient's name, if other than signature: _____ Date: _____