New Patient Registration

Patient Information

Full Name: _____ Date: _____
First MI Last

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

Age: _____ Birth Date: _____ Female: _____ Male: _____

Social Security Number: _____ Email Address: _____

Home Phone: _____ Work Phone: _____ Cell/Other: _____

I prefer to receive calls at: (check) ☐ Home ☐ Work ☐ Cell/Other I am: (check) ☐ under Age18

Marital Status: (check) ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

Employer: _____ Occupation: _____

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

Spouse's Name: _____ Spouse's Date of Birth: _____

Emergency Contact: _____Emergency Contact Phone Number: _____

Referred by: (check) ☐ Physician _____ ☐ Friend_____ ☐ Website_____ ☐ Other_____

Payment Information

Person Responsible for Payment: _____

Social Security Number: _____ Phone: _____ Date of Birth: _____

Insurance Information

Do you have health insurance? ☐ Yes _____ No

Primary Insurance	Secondary Insurance
Insurance Company:	Insurance Company:
Policy Holder's Name:	Policy Holder's Name:
Relationship to Patient:	Relationship to Patient:
Policy Holder's Birth Date:	Policy Holder's Birth Date:
Group Number:	Group Number:
Policy ID Number:	Policy ID Number:

Please have your insurance card and driver's license ready so they can be copied for the clinic's records.

Consent for Treatment

Assignment & Release - *By signing below, I authorize Dr. Polsky/Dr. Sharpe to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Dr. Polsky/Dr. Sharpe and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

By signing below, I give my consent for examination and the performance of any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient.

Signed _____ *Date* _____

New Britain Chiropractic, William Z Polsky DC, Jeanne M Sharpe DC
904 Town Center, New Britain, PA 18901
Phone: 215-340-2797 Fax: 215-340-2231

Personal History Form

Name_____ Date _____

The following is a confidential questionnaire which will help us determine the best possible course of treatment for you. Please take your time and complete the information accurately. Thank you!

How would you describe your chief complaint at this time?

_____

_____

When did it start?_____
(Include month and year, day if known)

What makes the pain worse? _____

What makes the pain better? _____

How would you describe your pain? _____

At what time of the day or week is your pain worse? _____

The pain is: ___ Intermittent ___ Constant

Have you had this problem in the past? _____ If so, how often? _____

Is your pain the result of a motor vehicle accident? _____

Have you filed a legal suit? _____

Is your pain the result of a work related injury? _____

If so, have you filed a worker's compensation claim? _____

Please list accidents, injuries, surgeries, and hospitalizations you have had.

_____ Date or Age _____

_____ Date or Age _____

_____ Date or Age _____

_____ Date or Age _____

_____ Date or Age _____

_____ Date or Age _____

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Personal History Form

Name_____ Date_____

Do you or other family members have a history of any of the following?

_____Arthritis	__ Self	Family member _____
_____Cancer	__ Self	Family member _____
_____Diabetes	__ Self	Family member _____
_____Heart Disease	__ Self	Family member _____
_____Hypertension	__ Self	Family member _____
_____Hypoglycemia	__ Self	Family member _____
_____Kidney Disease	__ Self	Family member _____
_____Depression	__ Self	Family member _____
_____Mental Illness	__ Self	Family member _____
_____Stroke	__ Self	Family member _____

Do you drink coffee or black tea? _____ If so, how much per day? _____

Do you smoke tobacco? _____ If so, how much per day? _____

Do you drink alcohol? _____ If so, how often? _____

How many times a week do you engage in physical activity that is sufficiently prolonged and intense to cause sweating and raise you heart rate?_____

When you engage in the physical activity noted above, what is the average duration of activity?
____ Less than 10 minutes ____ 10 – 20 mins ____ 20 – 30 mins ____ 30 – 60 mins ____ over 60 mins

At work, how many days per week do you engage in tasks that are intense enough to cause sweating and a rapid heart rate?
_____

Please rate your level of fitness (0 = very poor, 5 = average, 10 = excellent) _____

What medications, vitamins, supplements, herbs do you take?

Name	**Reason**
_____	_____
_____	_____
_____	_____
_____	_____

Please list any allergies that you have:

_____

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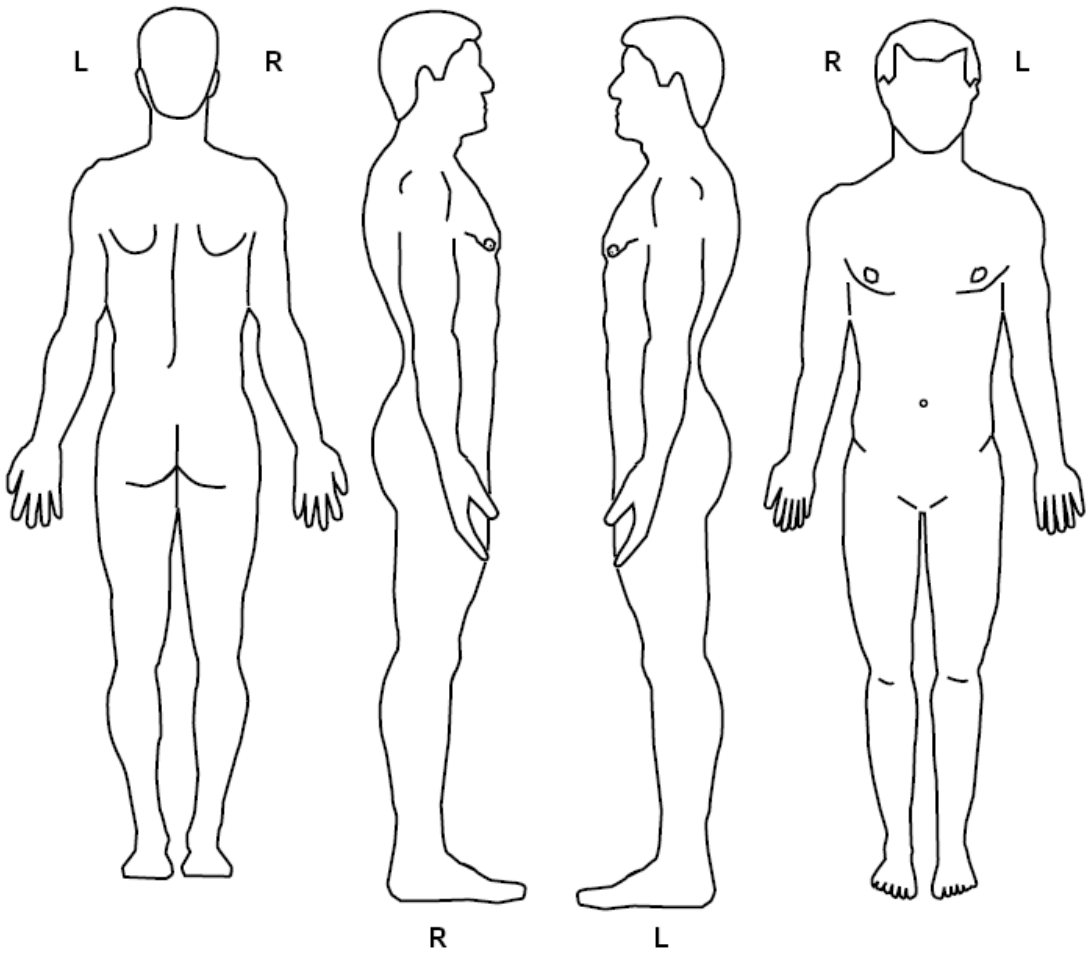
PAIN DRAWING

Name: _____ Date: _____

Please be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s), mark areas of radiating pain, and include all affected areas. You may draw in the face as well.

Numbness ----------	Pins & Needles ooooooo	Burning xxxxxxxxx Pain xxxxxxxx	Stabbing ////////// Pain //////////	Aching (((((((((Pain (((((((



VISUAL ANALOGUE SCALE

Please mark on the line the pain level that most accurately represents your pain:

NO PAIN:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**UNBEARABLE PAIN**
a) Right Now:----	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	_____
b) Average Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	_____
c) At Best ------	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	_____
d) At Worst-------	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	_____

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Name: _____ Date: _____

REVIEW OF SYSTEMS

Do you have any of the following? Please circle yes or no for each item.

General:

Recent weight loss of more than 10 pounds	Yes	No
Recent weight *gain of more* than 10 pounds	Yes	No
Seen primary care physician in last year	Yes	No
Fever	Yes	No
Chills	Yes	No
Night Sweats	Yes	No

Cardiac

Chest Pain	Yes	No
Shortness of Breath	Yes	No

Respiratory

Wheezing	Yes	No
Pneumonia	Yes	No
Chronic Cough	Yes	No

Gastrointestinal:

Abdominal pain	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Diarrhea	Yes	No
Liver problems	Yes	No

Skin:

Open sores	Yes	No
New moles	Yes	No
Poor healing	Yes	No
Skin infection	Yes	*No*

Hematologic/Oncologic:

Easy bruising	Yes	No
Blood thinning medications	Yes	No
Blood transfusion	Yes	No
Organ transplant	Yes	No

Bones/ Joints:

Shoulder pain	Yes	No
Wrist or hand pain	Yes	No
Hip pain	Yes	No
Knee pain	Yes	No
Lupus	Yes	No
Muscle weakness	Yes	No
Fibromyalgia	Yes	No

Genitourinary:

Abnormal kidney fimetion	Yes	No
Pain with urination	Yes	No
Frequent urinary infections	Yes	No

Mental Health:

Sleep disturbance	Yes	No
Feeling *of* hopelessness	Yes	No

Nervous System:

Headaches	Yes	No
Tremors	Yes	No
Poor speech	Yes	No
Changes in vision	Yes	No

Endocrine:

Thyroid problems	Yes	No

Patient's initials _____ Date _____

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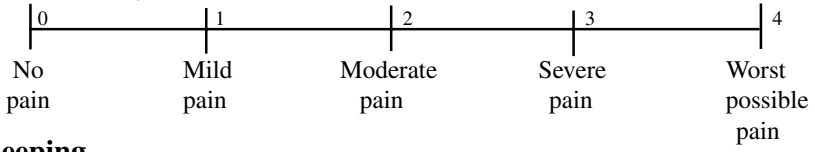
Functional Rating Index

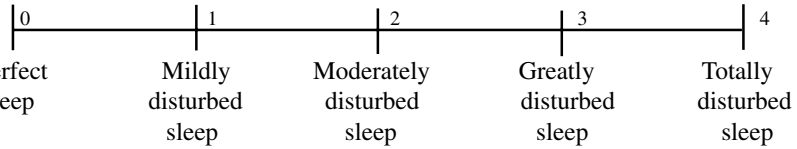
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

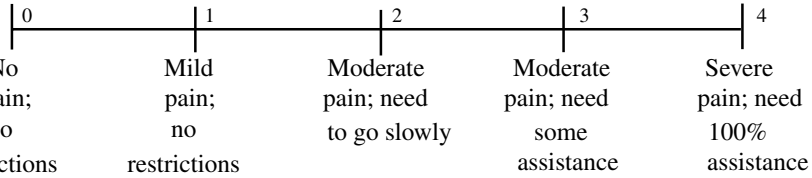
1. Pain Intensity



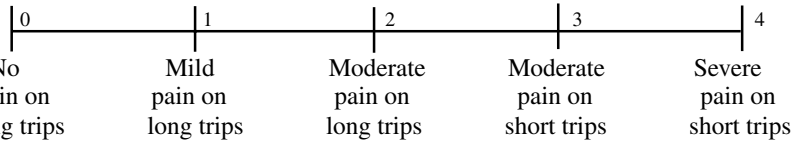
2. Sleeping



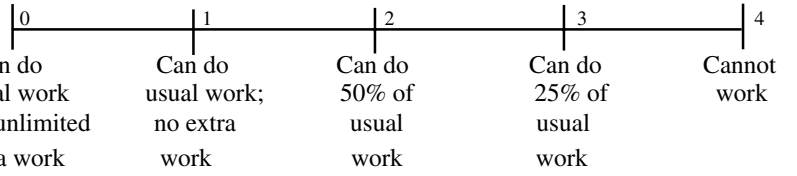
3. Personal Care (washing, dressing, etc.)



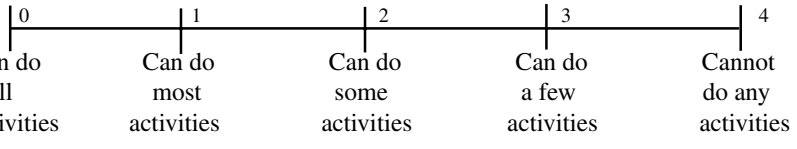
4. Travel (driving, etc.)



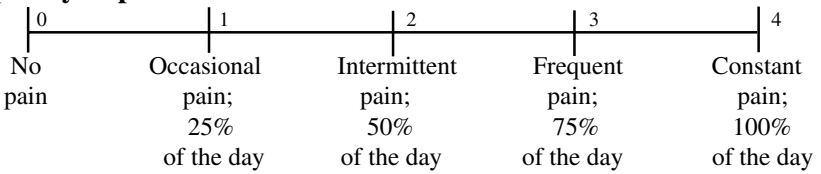
5. Work



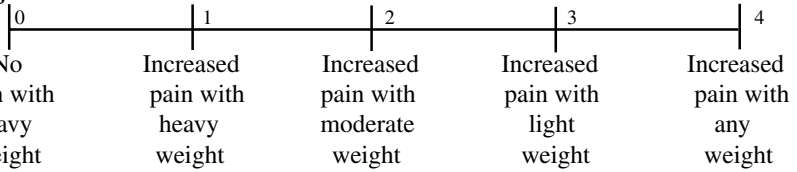
6. Recreation



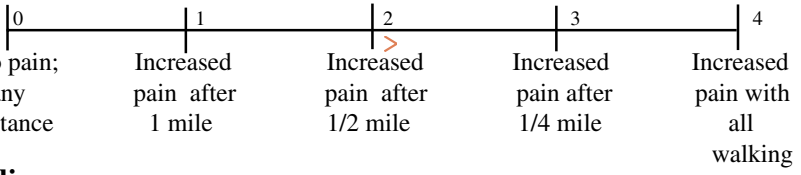
7. Frequency of pain



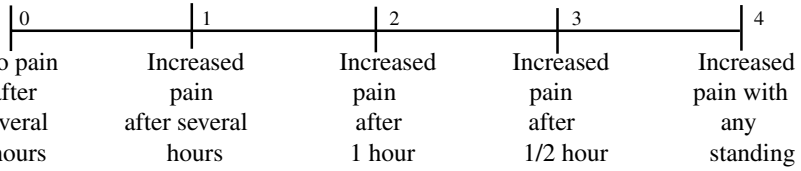
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

_____
Signature

_____
Date

Total Score _____

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will respect the privacy of your health information.

There are several circumstances in which we may have to use your health care information.

- We may have to disclose your health care information to another health care provider or hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restrictions are binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time, however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information, if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

_____ _____

PRINTED NAME AUTHORIZED PROVIDER REPRESENTATIVE

_____ _____

SIGNATURE DATE

_____

DATE