

FANWOOD BACK RELIEF CENTER

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____ Sex: M F Email _____

*Best contact number to reach you _____ Cell / Home / Work

Is it OK to text or email you appointment reminders? Yes / No

If yes, please indicate cell phone carrier (AT&T, Verizon, Sprint, other.) _____

Social Security # (for insurance purposes only) _____

Emergency Contact & Phone # _____ Name of Spouse\Guardian (if minor) _____

Occupation _____

Your Primary Care Physician (PCP) _____ Phone _____

How did you hear about us? _____

(Newspaper ad, Online, Existing Patient)

Do you have health insurance? Yes / No Is your injury related to an automobile or work related accident? Yes / No

List your chief complaints in order of severity:

1. _____ When did it start? _____ (gradual/sudden)

2. _____ When did it start? _____ (gradual/sudden)

What is the severity of your problem?

(best) 1 2 3 4 5 6 7 8 9 10 (worst)

Chronology/timing/prior episodes:

Have you had this condition before? _____

How often does the pain occur (please circle one)? Constant? Episodic? Occasional?

How many times a (please circle one) day/week/month?

Type of pain (please circle one): sharp, dull, aching, shooting Is your condition getting worse? Yes/No

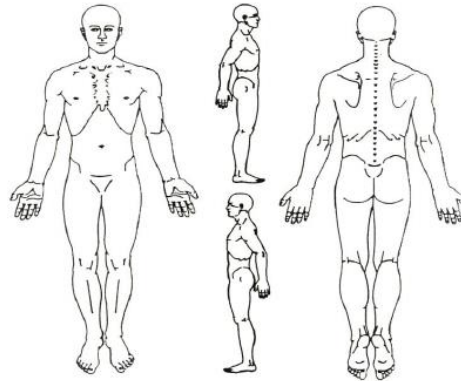
What makes it feel better? _____

What make it feel worse? _____

Does your pain travel? Yes / No If yes, where _____

If Neck Pain – Does it shoot down your arms?	Yes	No
Any numbness or tingling in arms or hands	Yes	No
Any weakness in arms/hands	Yes	No
If Back Pain - Does it shoot down your legs/feet	Yes	No
Any numbness or tingling in legs or feet	Yes	No
Any weakness in legs/feet	Yes	No

Indicate Your Pain on the Diagram:



How are your symptoms affecting your lifestyle? (Eg. job, relationships, recreational activities, household chores)?

Do you currently have, or have you had any of the following conditions or symptoms? Circle all that apply

- | | | | |
|--------------------|-----------------------|------------------|----------------|
| Headaches | Wrist of hand pain | Stomach Problems | Depression |
| Knee Pain | Numbness/tingling | Ringin in ears | Anxiety |
| Neck Pain | Chest Pain | Loss of balance | Shoulder pain |
| Low back pain | Heart Conditions | Nervousness | Kidneys |
| Hip Pain | High blood pressure | Cancer | Bladder |
| Fatigue | Shortness of breath | HIV | Arthritis |
| Vertigo | Loss of smell/taste | Dizziness | Joint swelling |
| Jaw pain | TMJ | Insomnia | Stomach/GI |
| Diabetes (Insulin) | Diabetes (No Insulin) | | |
- Other: _____

Treatment History/relevant prior injuries:

Have you seen anyone else about chief complaint? _____

If yes, what services were performed (circle all that apply) Chiropractic/Physical Therapy/Acupuncture/Pain Management

Provider Name _____ Facility _____

Was the treatment(s) successful? _____

List your hospitalizations, operations and/or serious illnesses _____

List all medications you are currently taking _____

List any allergies _____

Social habit use and how often:

Tobacco? _____

Alcohol? _____

Is there a family History of:

Father's side: Heart Disease Arthritis Cancer Diabetes other

Mother's side: Heart Disease Arthritis Cancer Diabetes other

HIPAA Compliance Acknowledgement

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

This notice is in effect as of April 15, 2003.

PATIENT'S STATEMENT OF AUTHORIZATION AND ACKNOWLEDGEMENT

Eric Chludzinski, P.C.

- a) Is required by federal law to maintain the privacy of your protected health information (PHI), and to provide you with a copy of this Privacy Notice detailing Eric Chludzinski P.C. legal duties and privacy practices with respect to your PHI.
- b) May be required by State law to maintain greater restrictions on the use or release of your PHI than that which is provided under federal law. Eric Chludzinski, P.C. is required to, and will comply with all required State statutes.
- c) Is required to abide by the terms of this privacy notice.
- d) Reserves the right to change the terms of this privacy notice to make the new privacy notice provisions effective for your entire PHI that it maintains.
- e) Will distribute any revised Privacy Notice to you prior to implementation.
- f) Will comply with our complaint policy, and will not retaliate against you for filing a complaint.

By subscribing my name below, I acknowledge that I have read and understood this Privacy Notice. Furthermore, I give Eric Chludzinski, P.C. the expressed written consent to display my name in any "In-Office" usages, including but not limited to sign-in sheet, files, charts, mobile devices, and e-mail. I also understand that if my name is requested to be used for promotional purposes outside of the office, a separate acknowledgement of permission will made in writing.

ACCEPT TERMS: _____

PATIENT SIGNATURE DATE