New Patient Health History Form

235 Mamaroneck Ave Ste 105
White Plains, NY 10605

Confidential Patient Information

How did you hear about our office: ◯ Yellowbook ◯ Insurance Directory ◯ Brochure

◯ Doctor Referral: _____ ◯ Internet: What Website? _____ ◯ Walk in

◯ Patient Referral: _____◯ Pennysaver ◯ Newspaper Ad- newspaper _____

Patient Name: _____ **Social Security** #:_____

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

Age: _____ **Date of Birth**: _____ **Home Phone**: _____

Cell Phone: _____ **Work Phone**: _____ **Marital Status**: _____

Occupation: _____ **Employer**: _____

E-mail: _____**Nearest living relative & Phone #** _____

Spouse Name: _____ **Spouse work #:** _____

Reason For Treatment: Please Answer All Questions. Insurance Companies Require for Authorization For Treatment.

Main Complaint: _____

Additional Complaints: _____

When Did It Start: _____

What Brought It On: □ Auto Accident □ Work Injury □ Yard Work □ Household Chores □ Sports Injury
□ Lifting Something □ A Fall □ Exercising □ Shoveling Snow □ Slept Wrong □ No Specific Reason
□ Other Please specify: _____

What Makes It Worse: □ Work □ Sleeping □ Lying Down □ Sitting □ Driving □ Household Chores
□ Yard Work □ Lifting □ Exercising □ Walking □ Taking Care Of Children □ Increased Activity
□ Other Please Specify: _____

What Makes It Better: □ Sitting □ Lying Down □ Sleeping □ Resting □ Exercise □ Shower □ Heat □ Ice
□Increased Activity □ Stretching □ Nothing □ Other Please Specify: _____

Current Medications: □ Tylenol/Acetaminophen □ Motrin/Advil/Ibuprofen □ Aleve/Naproxen □ Asprin
□ Muscle Relaxer: _____ □ Pain Medication: _____ □ Neutontin
□ Prescription Anti-Inflammatory _____ □ Other _____

Other Doctors You Are Seeing For This Problem:
_____

Current Treatments:

_____

Have You Had A Similar Condition In The Past? _____ How Long Ago? _____

How Was It Treated: _____

Who Is Your Primary Care Physician? Name _____ Phone: _____
Address: _____

Allergies:_____

Please List Any Major Health Problems:_____
_____
_____

<u>Insurance Information</u>:

Is This Due To An Auto or Work Related Injury? _____ Has A Claim Been Filed? _____

Health Insurance Co.: _____ Policy_____ Primary Insured: _____

Authorization of Payment: I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand and agree that this office will prepare any necessary paperwork to assist me in making collection from the responsible insurance carrier and that any amount authorized to be paid directly to this office, will be credited to my account upon receipt of payment. However, I also understand and agree that all serviced rendered to me are charged directly to me and that I am personally responsible for payment for those services in full. I also understand that if I suspend or discontinue my care for any reason, any fees for services rendered are due and payable immediately. I also agree to assist this office in any way necessary, in collecting any payments due for services rendered to me by this office, from the responsible insurance carrier.
Consent to Treatment: I consent to Physical Therapy, Chiropractic, Massage Therapy, Rehabilitations and related services at this facility. In doing so, I understand, acknowledge and affirm that such services may involve bodily contact, touching and/or direct contact of a sensitive nature. I also understand, acknowledge and affirm that on a rare occasion these services may lead to a temporary increase in pain or soreness and on an even rarer occasion a more serious injuries may occur in patients compromised with certain concomitant disease or illness. This includes the 1 in 1 million to 1 in 40 million chance of cerebral vascular accidents during manipulation or mobilization of the neck, the same probability of this occurring while turning your neck or having your hair washed at a salon. This is generally attributed to an underlying defect in the vertebral or basilar artery.
Treatment of Minors: I, as a parent or guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment and waive any claim I may have resulting from failure to do so.
Waiver and Release: I hereby release, discharge, and aquit this facility, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action or loss of any kind arising from my refusal to accept, receive or allow emergency and/or medical services, included but not limited to ambulance service, EMT, physician or urgent care service.
By signing below, I acknowledge and agree to the above:

Patient Signature: _____ Date: _____

Guardian or Responsible Parties Signature: _____

Guardian or Responsible Parties Social Security #: _____