Norwalk Sports & Spine

CONFIDENTIAL HEALTH INFORMATION

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

Jason Queiros, DC
Andrew Zomick, DC
488 Main Avenue 2nd Fl
Norwalk, CT 06851
(203) 842-8502
www.NorwalkSportsandSpine.com

Today's Date (MM/DD/YYYY) _____

Have you consulted a chiropractor before? ○ No ○ Yes _____ When?

Patient Number (office use only) _____

Whom may we thank for referring you? _____

If so, whom? _____

Age _____

Gender ○ Male ○ Female

Race ○ American Indian ○ Alaskan Native ○ Asian ○ Black/African American ○ Native Hawaiian/ Pacific Islander ○ Other ○ White ○ Decline to answer

Ethnicity ○ Hispanic or Latino ○ Not Hispanic or Latino ○ Decline to specify

Birth Date (MM/DD/YYYY) _____

Your Last Name _____ Your Social Security Number _____

Your First Name _____ Your Middle Name (or Initial) _____

Smoking Status (age 13 and over) ○ Never A Smoker ○ Former Smoker ○ Current Every Day Smoker ○ Current Some Day Smoker ○ Heavy Smoker ○ Light Smoker

Address _____

Marital Status ○ Married ○ Single ○ Divorced ○ Widowed ○ Separated

City _____ State/Province _____ ZIP/Postal Code _____ Preferred Language _____

Home Phone _____ Cell Phone _____ Spouse's Name _____

Email Address _____ Children's Name and Age _____

Emergency Contact _____ Emergency Contact's Phone _____

Your Occupation _____

Your Employer _____ Work Phone _____

Address _____

Preferred method of contact for future appointment reminders?
○ Cell Phone ○ Text Message ○ Work Phone ○ Email

City _____ State/Province _____ ZIP/Postal Code _____

Primary Care Provider's Name _____

Skip if Insurance Card Present

Insurance Carrier _____ Policy Number _____

Insured's Last Name _____ Birth Date (MM/DD/YYYY) _____ Who carries this policy? ○ Self ○ Spouse ○ Parent

Insured's First Name _____ Insured's Middle Name (or Initial) _____

Insured's Employer _____

Employer's Address _____ City _____ State _____ Zip _____ Employer's Phone _____

CONFIDENTIAL HEALTH INFORMATION

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

Primary Complaint
The primary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
◯ An accident or injury
◯ Work ◯ Auto ◯ Other _____

Grade the pain on a 0-10 scale ___/10
Describe the pain _____

Onset (When did you first notice your current symptoms?) _____

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

Secondary Complaint
The secondary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
◯ An accident or injury
◯ Work ◯ Auto ◯ Other _____

Grade the pain on a 0-10 scale ___/10
Describe the pain _____

Onset (When did you first notice your current symptoms?) _____

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

Additional Complaint
The additional symptom that prompted me to seek care today is: _____

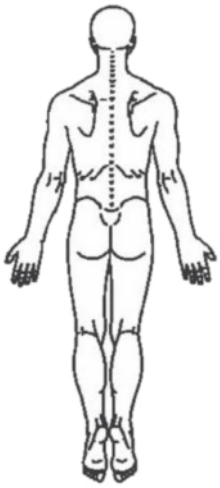
And are the result of (darken circle):
◯ An accident or injury
◯ Work ◯ Auto ◯ Other _____

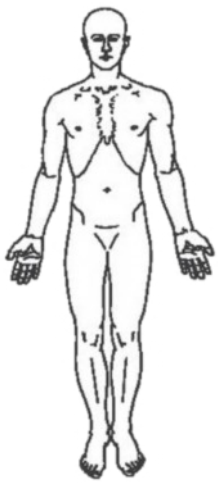
Grade the pain on a 0-10 scale ___/10
Describe the pain _____

Onset (When did you first notice your current symptoms?) _____

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

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





1. What else should the doctors know about your current condition? _____

2. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

3. 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		NONE ◯
◯	◯ Osteoporosis	◯	◯ Arthritis	◯	◯ Scoliosis	◯	◯ Neck pain	◯	◯ Back problems	◯	◯ Hip disorders	
◯	◯ Knee injuries	◯	◯ Foot/ankle pain	◯	◯ Shoulder problems	◯	◯ Elbow/wrist pain	◯	◯ TMJ issues	◯	◯ Poor posture	

b. Neurological

Had Have		Had Have		Had Have		Had Have		Had Have		Had Have		NONE ◯
◯	◯ Anxiety	◯	◯ Depression	◯	◯ Headache	◯	◯ Dizziness	◯	◯ Pins and needles	◯	◯ Numbness	

c. Cardiovascular

Had Have		Had Have		Had Have		Had Have		Had Have		Had Have		NONE ◯
◯	◯ High blood pressure	◯	◯ Low blood pressure	◯	◯ High cholesterol	◯	◯ Poor circulation	◯	◯ Angina	◯	◯ Excessive bruising	

d. Respiratory

Had Have		Had Have		Had Have		Had Have		Had Have		Had Have		NONE ◯
◯	◯ Asthma	◯	◯ Apnea	◯	◯ Emphysema	◯	◯ Hayfever	◯	◯ Shortness of breath	◯	◯ Pneumonia	

e. Digestive

Had Have		Had Have		Had Have		Had Have		Had Have		Had Have		NONE ◯
◯	◯ Anorexia/bulimia	◯	◯ Ulcer	◯	◯ Food sensitivities	◯	◯ Heartburn	◯	◯ Constipation	◯	◯ Diarrhea	

f. Sensory

Had Have		Had Have		Had Have		Had Have		Had Have		Had Have		NONE ◯
◯	◯ Blurred vision	◯	◯ Ringing in ears	◯	◯ Hearing loss	◯	◯ Chronic ear infection	◯	◯ Loss of smell	◯	◯ Loss of taste	

g. Skin

Had Have		Had Have		Had Have		Had Have		Had Have		Had Have		NONE ◯
◯	◯ Skin cancer	◯	◯ Psoriasis	◯	◯ Eczema	◯	◯ Acne	◯	◯ Hair loss	◯	◯ Rash	

_____
Patient name

_____
Patient Number
(office use only)

_____
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 ○

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 ○

j. Constitutional

Had Have ○ ○ Fainting | Had Have ○ ○ Low libido | Had Have ○ ○ Poor appetite | Had Have ○ ○ Fatigue | Had Have ○ ○ Sudden weight gain/loss (circle one) | Had Have ○ ○ Weakness | NONE ○

Patient name _____

Patient Number (office use only) _____

○ All other systems negative

Past Personal, Family and Social History

Initials _____

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

PERSONAL

4. 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			
○	○	HIV Positive			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

7. Allergies

Allergic to any medications or food?

Yes ○ No ○ If Yes please list: _____

5. 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: _____

6. 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
○	○	Medications

(Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals): _____

8. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Other injury _____

Consultation Notes

9. Family History

Some health issues are hereditary. Tell the doctors about the health of your immediate family members.

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	_____	○	○				
		○	○				

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

_____

11. Social History

Tell the doctors about your health habits and stress levels.

SOCIAL

Alcohol use	○ Daily ○ Weekly	How much? _____	Interested in Diet/Weight loss?	○ Yes	○ No
Coffee use	○ Daily ○ Weekly	How much? _____	Interested in Acupuncture?	○ Yes	○ No
Tobacco use	○ Daily ○ Weekly	How much and what type? _____			
Exercising	○ Daily ○ Weekly	How much and what type? _____			
Pain relievers	○ Daily ○ Weekly	How much? _____			
Soft drinks	○ Daily ○ Weekly	How much? _____	Use recreational drugs?	○ Yes	○ No
Water intake	○ Daily ○ Weekly	How much? _____ /day _____			

Hobbies: _____

Doctor's Initials _____

12. 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	○	○	○	○

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

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

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

16. What is your preferred sleeping position? _____

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

18. What would be the most significant thing that you could do to improve your health? _____

19. In addition to the main reason for your visit today, what additional health or fitness 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 confirm 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 office.**

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.**

Patient (or Guardian's)signature _____ Date (MM/DD/YYYY) _____

Consultation Notes

Patient name _____

Patient Number (office use only) _____

Doctor's Initials _____

Norwalk Sports & Spine
Patient Consent for Use and Disclosure
Of Protected Health Information
488 Main Avenue Norwalk, CT 06851

I hereby give my consent for Norwalk Sports & Spine to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Norwalk Sports & Spine notice of privacy practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Norwalk Sports & Spine reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Norwalk Sports & Spine, 488 Main Avenue, 2nd Floor, Norwalk, CT 06851.

With this consent Norwalk Sports & Spine may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent Norwalk Sports & Spine may mail to my home or other alternative location any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With the consent of Norwalk Sports & Spine may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Norwalk Sports & Spine restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Norwalk Sports & Spine to use and disclose of mu PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Norwalk Sports & Spine may decline to provide treatment to me.

Patients Name_____ Date _____

Signature of patient or legal Guardian _____

Print Name of Patient or Legal Guardian_____

Norwalk Sports & Spine
Informed Consent
488 Main Avenue Norwalk, CT 06851

Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic xrays, on me (or on patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as backup for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I Understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the abovenamed procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment

PATIENT SIGNATURE_____ DATE_____