PLAWSKI CHIROPRACTIC
Your Answer To Pain Relief

NEW PATIENT CONFIDENTIAL INFORMATION INTAKE FORM
PLAWSKI CHIROPRACTIC, PLLC

Date: _____ Referred by: _____

If you have an injury, is it related to an accident? **YES** **NO** **N/A** (circle one)

PATIENT DATA: ***USE BLACK INK TO FILL OUT THE FORMS***

Name _____ Address: _____

City: _____ State: _____ Zip Code: _____

E-MAIL: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____ Best Number To Call: _____

Date Of Birth: _____ Age: ____ Marital Status: _____ # Of Children: _____

Occupation: _____ Work Address: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Primary Care Physician: _____ Phone: _____

Office Location: _____

INSURANCE INFORMATION: Name of person responsible for payment: _____

Insurance Carrier Name: _____ Member ID: _____

Group#: _____ Do you have secondary insurance?: **YES** or **NO** (circle). If yes, fill out below:

Name of 2nd Insurance: _____ Member ID: _____

Group#: _____ Name of the Insured: _____

Is your insurance related to an automobile accident or No-Fault? **YES** or **NO** (circle one)

Is your insurance related to a work related accident? **YES** or **NO** (circle one)
If you answered yes to either of the above please fill out below:

Name of Insurance Carrier: _____ Claim #: _____

Carrier Phone Number: _____ Claim Adjuster's Name: _____

Please read and sign below:
I understand and agree that health and accident insurance are arrangements between an insurance carrier and myself. I understand that this office will prepare any necessary reports and forms to assist me in making collections from the insurance carrier and that any amount authorized to be paid will be paid directly to my account upon receipt. I permit this office to endorse co-issued remittances for the convenience of credit to my account. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment of services rendered to me. I understand that if I suspend or terminate my care or treatment, and fees for services will be immediately due and payable. I further understand that this office processes my claims as a courtesy to me but by doing so it is not a guarantee of payment by your insurance carrier.

Patient Signature: _____ Date: _____

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ ***Date*** _____

1. Describe your symptoms _____

_____

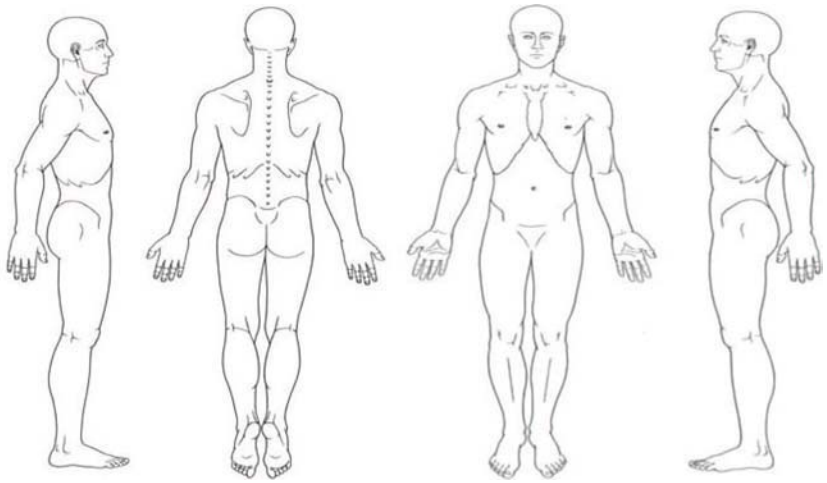
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *Unbearable*

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

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8. Who have you seen for your symptoms?

① No One
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

_____

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ ***Date*** _____

Patient Health Questionnaire - page 2

ACN Group, Inc PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ][ ][ ] *Feet Inches* Weight [ ][ ][ ] lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
○	○	Headaches	○	○	High Blood Pressure	○	○	Diabetes
○	○	Neck Pain	○	○	Heart Attack	○	○	Excessive Thirst
○	○	Upper Back Pain	○	○	Chest Pains	○	○	Frequent Urination
○	○	Mid Back Pain	○	○	Stroke			
○	○	Low Back Pain	○	○	Angina	○	○	Smoking/Use Tobacco Products
						○	○	Drug/Alcohol Dependence
○	○	Shoulder Pain	○	○	Kidney Stones			
○	○	Elbow/Upper Arm Pain	○	○	Kidney Disorders	○	○	Allergies
○	○	Wrist Pain	○	○	Bladder Infection	○	○	Depression
○	○	Hand Pain	○	○	Painful Urination	○	○	Systemic Lupus
			○	○	Loss of Bladder Control	○	○	Epilepsy
○	○	Hip/Upper Leg Pain	○	○	Prostate Problems	○	○	Dermatitis/Eczema/Rash
○	○	Knee/Lower Leg Pain				○	○	HIV/AIDS
○	○	Ankle/Foot Pain	○	○	Abnormal Weight Gain/Loss			
			○	○	Loss of Appetite	***Females Only***		
○	○	Jaw Pain	○	○	Abdominal Pain	○	○	Birth Control Pills
						○	○	Hormonal Replacement
○	○	Joint Swelling/Stiffness	○	○	Ulcer	○	○	Pregnancy
○	○	Arthritis	○	○	Hepatitis	○	○	
○	○	Rheumatoid Arthritis	○	○	Liver/Gall Bladder Disorder			
						Other Health Problems/Issues		
○	○	General Fatigue	○	○	Cancer	○	○	
○	○	Muscular Incoordination	○	○	Tumor	○	○	
○	○	Visual Disturbances	○	○	Asthma	○	○	
○	○	Dizziness	○	○	Chronic Sinusitis			

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ ***Date*** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ ***Date*** _____

PLAWSKI CHIROPRACTIC
Your Answer To Pain Relief

Plawski Chiropractic
280 N Central Avenue, Ste 211
Hartsdale, NY 10530
914-289-1700

AUTHORIZATION FOR CHIROPRACTIC TREATMENT

I, the undersigned, a patient in this office hereby authorize Dr. Plawski,
(and whomever she may designate as her assistant) to administer such treatment as is necessary, and to perform the following therapy and manipulation and such additional therapy or procedures as are considered necessary on the basis of findings during the course of said treatment.

I hereby certify that I have read and fully understand the above Authorization for Chiropractic treatments, the reasons why the above named treatment is considered necessary, its advantages and possible complications, if any, as well as possible alternative modes of treatment, which were explained to me by Dr. Plawski.

I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Patient's Signature: _____ Date: _____

Print Patient's Name: _____

Plawski Chiropractic, PLLC
280 N Central Avenue, Ste 211
Hartsdale, NY 10530
914-289-1700

Acknowledgement of Receipt of Medical Information Privacy Notice and Consent

By signing this form. you are granting consent to Plawski Chiropractic, PLLC to use and disclose your protected health information for the purposes of treatment. payment and health care operations. Our Notice cf Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

I acknowledge that I have received. or have been offered, a copy of the Medical Information Privacy Notice of Plawski Chiropractic PLLC ("Notice") to review, and I have reviewed it, or have been informed that I have a right to review it, prior to signing this consent.

I hereby consent to the use and disclosure of my personal medical information by Plawski Chiropractic,PLLC to carry out treatment, payment and health care operations as described in the Notice, which contains a more complete description of the uses and disclosures to which my personal medical information may be put or subjected in the course of treatment, payment, and health care operations.

Plawski Chiropractic, PLLC has informed me that they may disclose or use my personal medical information to carry out treatment, payment or health care operations as described in the Notice.

I have been informed that the terms of the Notice may change from time to time, and that I may obtain a copy of the most recent Notice by requesting it in writing, or by requesting a copy of the most recent Notice at the time of any office visit.

I have been informed that I have the right to request that Plawski Chiropractic, PLLC restrict how my personal medical information is used or disclosed to carry out treatment, payment, or health care operations, but that Plawski Chiropractic, PLLC has the right to refuse to agree to the requested restrictions. I also have been informed that if Plawski Chiropractic, PLLC agrees to a restriction, such agreement is legally binding upon them.

I have been informed that I have the right to revoke this Consent in writing at any time except to the extent Plawski Chiropractic, PLLC has taken in reliance upon this Consent prior to revocation.

I have been informed that once Plawski Chiropractic,PLLC transmits information, on my behalf to another provider, or anyone else I request, they can not be held responsible for the confidentiality once the document(s) leave their office.

Patient's Signature: _____ Date: _____

Print Patient's Name: _____