Spinal Wellness Center
2021 Western Ave. Ste 102
Albany, NY 12203

Date: ____________

PATIENT INFORMATION

Name: ________________________ **Preferred Name (Nickname):** ________________

Address: ______________________ **City:** _______________ **State:** _______ **Zip** _______

Social Security #: ___ - ___ - ______ **Marital Status:** S M W D **Spouse:** ____________

Language: ___ English ___ Spanish ____ Indian ____ Japanese ____ Chinese ____ Korean
____ French ____ German ____ Russian ___ Other ________________________

Race: ____ White ______ American Indian or Alaska Native _____ Asian
______ Native Hawaiian/other Pacific Islander ____ Black or African American
______ Hispanic or Latino ______ Decline to Answer

Ethnicity: ____ Hispanic or Latino ____ Not Hispanic or Latino _____ Decline to Answer

DOB: ___/___/____ **Sex:** ______ Male ____ Female

Occupation: ____

Employer: ____

Primary Care Provider: ____________________ **Date of Last visit to PCP:** ___/___/____

Whom may we thank for referring you? ________________________________

CONTACT INFORMATION

Home Phone: ( ) - __________ **Work Phone** ( ) - __________

Cell Phone: ( ) - __________ **Cell Carrier:** ____________________

Please check your contact preference: ___ Home ___ Work ___ Cell ___ Text ___ E-mail

Email address: ____

Emergency Contact: ____________________ **Phone Number:** ( ) - __________

Office Use Only:

Height: ____ feet _____ inches	Weight: ______ pounds	Blood Pressure:

INJURY/CONDITION

Will your visit today be for:____Injury/Health Condition/Pain____Wellness/Sports Performance

Was this injury related to an accident?____Yes____No if yes, was it ____work related ____auto

Reason for Visit: ______________________________

When did it start? ______________________ How did it start? ______________________

Please describe your condition: ______________________________

____

Rate your symptoms (0=best; 10=worst) ___/10

With time is your condition: _____getting better _____ getting worse _____ not changing

Are your symptoms constant or do they come & go: _____ constant _____ comes & go

What makes your symptoms worse? ____ Standing ____ sitting ____walking____ bending/lifting

____ Lying down _____sports/exercise _____self-care

What makes your symptoms better? ______________________________

What treatments have you already had for this condition: _____ None _____ medical ____ surgical

____Chiropractic _____ physical therapy______ massage ____ acupuncture

____Other: ______________________________

Have you had any recent imaging of the area?____ X-ray____ MRI____ CT Scan

____ Bone density/DEXA ____ Other ______________________

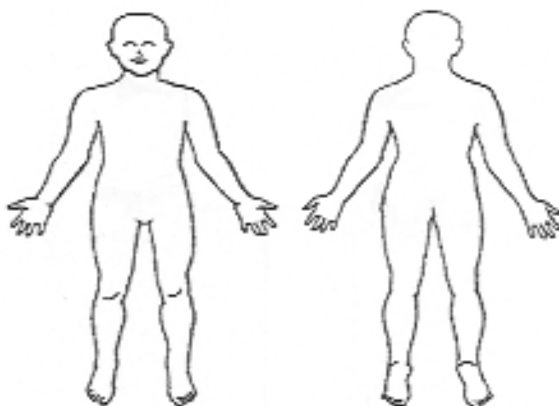
Does your condition interfere with your activities (work duties, daily life, social activities, and/or recreation)?____ Yes____ No

If yes, please list 3 activities that you have difficulty with:

1. ______________________________

2. ______________________________

3. ______________________________



HEALTH HISTORY: Have you had any of the following?								
	Y	N		Y	N		Y	N
Aids/HIV			High Blood Pressure			WOMEN ONLY:		
Anemia			High Cholesterol			Are you Pregnant?		
Anxiety			Multiple Sclerosis			If yes, Due Date		
Arthritis			Osteopenia			Abnormal/painful Menstrual Cycle?		
Asthma			Osteoporosis					
Bleeding disorders			Pacemaker			Miscarriage		
Cancer			Parkinson's disease			Menopause		
Chemical Dependency			Pinched nerve					
Depression			Polio			Prior Surgeries:	Date	
Diabetes (Type 1)			Prostate problem					
Diabetes (Type 2)			Prosthesis					
Epilepsy/Seizures			Psychiatric care					
Fractures			Rheumatoid arthritis					
Headaches			Stroke					
Heart Disease			Suicide attempt					
Hepatitis			Thyroid problems					
Hernia			Tumors					
Herniated disk			Ulcers					

Additional Information: ____________________

Family History: (does anyone in your immediate family have any of the following?)							
	Arthritis-Rheumatism		Diabetes (Type 1)		Osteoporosis/Osteopenia		OTHER: please list
	Autoimmune disorders		Diabetes (Type 2)		Stroke		
	Back/Spine Condition		Heart Disease		Thyroid Disorder		
	Cancer		High Blood Pressure		Mental Illness		

MEDICATIONS: PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING								
Brand Name	Generic Name	Strength	Dosage	Frequency	Quantity	Refills available	Prescribed by:	Date Started

VITAMINS: Please list all vitamins, herbs and supplements you are currently taking								
Brand Name	Generic Name	Strength	Dosage	Frequency	Quantity	Refills available	Prescribed by:	Date Started

ALLERGIES	REACTIONS

SOCIAL HISTORY
My work duties include: ____standing____sitting ____ light labor___heavy labor ___Other
My exercise level is:____intense___moderate____ light___minimal_____none
My current exercise includes: (list activities)
Do you smoke?:______Never_____Former Smoker______Current/Every Day Smoker ______ Current/Some Day Smoker _____ Packs/day
My other habits include:_____Alcohol consumption _____High Stress Level _____Caffeine (coffee, soda, tea)

Patient Signature: ______________________________ Date: ________________

CONSENT OT THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME ______________________________

DATE OF BIRTH: ___/___/______

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. **This information is kept private except uses involved in your healthcare.**

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and prior health information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that:

- I have the right to object to the use of my health information for directory purposes.
- I have access to a copy of the "Notice of Patient Privacy Rights" and they are available in the office.
- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations, and that the organization is not required to agree to the restrictions requested.
- I have the right to revoke this consent in writing, except to the extent that the organization has already taken action in reliance theron.
- I have the right to request a copy of my records. I understand that this request will need to be in written form and I must allow for 14 days notice. I also understand that there is a fee to obtain these copies.
- I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by recipient and that this information will no longer be subject to protection as protected health information.

I request the following additional restrictions to the use or disclosure of my health information:

____

I authorize The Sports and Spinal Wellness Center to speak with the following people regarding my healthcare:

____

- With my consent, The Sports and Spinal Wellness Center may call my home or other designated location, and leave a voice message in reference to any items that assist the practice in carrying out treatment, payment and health care operation, such as appointment reminders, insurance items and information pertaining to my clinical care.
- With my consent, The Sports and Spinal Wellness Center may mail to my home any items that assist the practice in carrying out the above listed operations.
- With my consent, The Sports and Spinal Wellness Center may send a narrative to my primary care doctor explaining my evaluation and treatment plan.

Patient Signature: ______________________________ Date: ___/___/______.

Informed Consent

I understand and am informed that, as in all health care, in the practice of chiropractic there is a small inherent risk of injury which includes but is not limited to, muscle strains, sprains, fractures, dislocation, intervertebral disc injury, and cardiovascular accident. I understand that my doctor will no be able to anticipate all potential complications, but will rely on clinical expertise and judgment to determine the correct course of treatment, which will be in my best interests considering all known facts. I understand that results are not guaranteed and that I have the opportunity to discuss the purposes and risks associated with all recommended evaluation and treatment procedures at any time.

I have read and understand the preceding statements and herby consent to voluntarily participate in orthopedic, neurologic and physical performance testing, as well as manipulative, and exercise/rehabilitation therapies as deemed appropriate. If at any time, I have further questions or decide not to continue to consent in treatment, I understand I have that right and it is my duty to notify my doctor.

______________________	______________________	__________
PRINT PATIENT NAME	SIGNATURE	DATE

If patient is a minor:

______________________	______________________	__________
PRINT PARENT/GUARDIAN NAME	SIGNATURE	DATE