

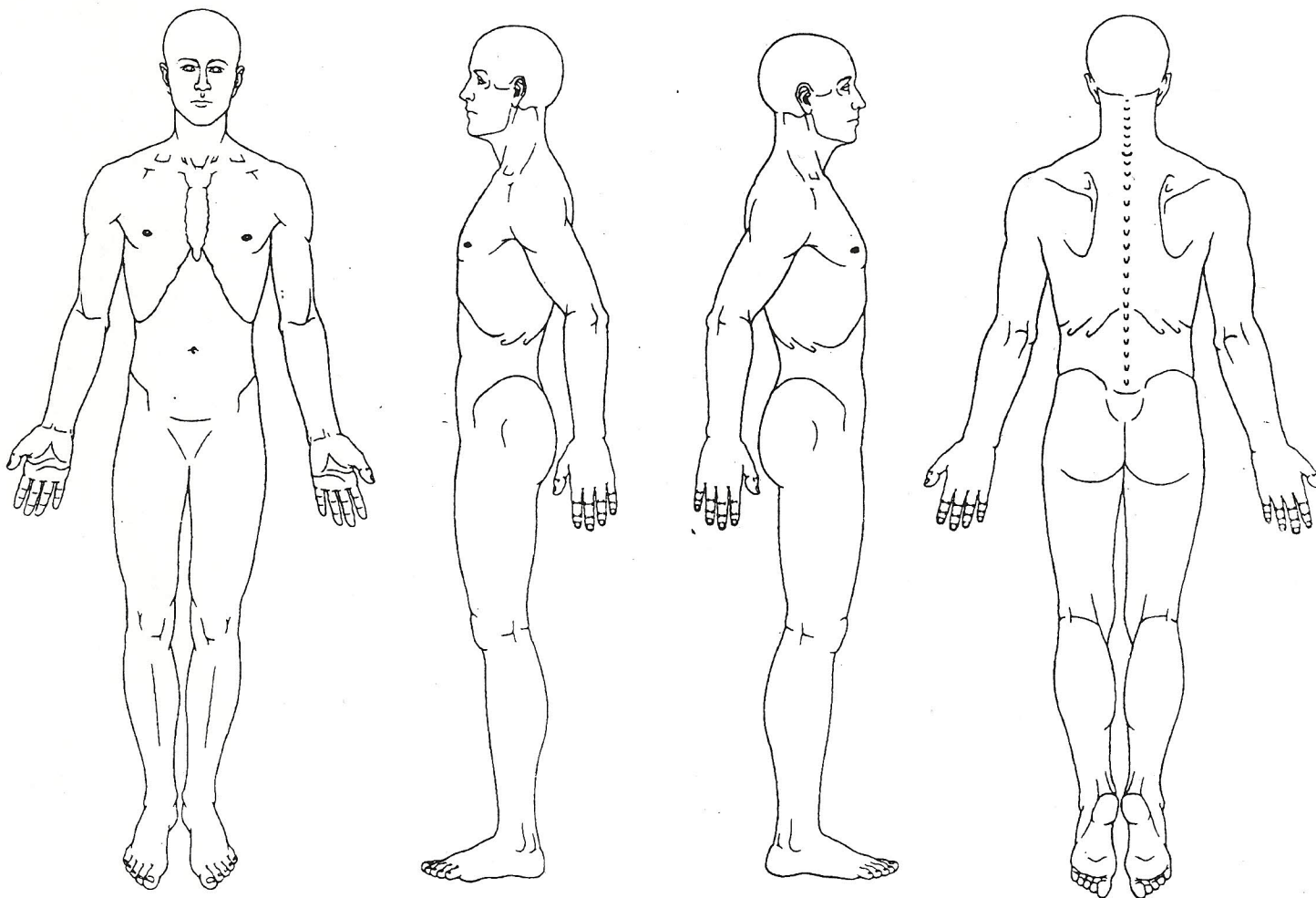
PAIN DRAWING

Name _____

Date _____

Using the following descriptive symbols, draw the location of your pain on body outlines below.
In addition, mark the level of your pain on the pain line at the bottom of the page.

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	OTHER
MMMM	=====	OOOOOOOO	////////	XXXX
MMM	=====	OOOOOOO	////////	XXX



Please make a slash through this line as to the level of your pain.

Patient Signature

PREVIOUS MEDICAL HISTORY

Smoker? Yes/No Packs/Day _____ Alcohol intake weekly yes/no (circle one)
Recreational Drugs (ever) Yes/No Allergies _____

Describe all surgeries

Describe all fractures _____

Describe all Medical Problems (Diabetes, High Blood Pressure, Heart, Kidney, etc.)

Describe all Hospitalizations:

List all Medications or Pills You Currently are Taking:

- _____
- _____
- _____
- _____

Have you ever had any of the following tests performed? & Why!

- MRI
- CAT SCAN
- X-RAYS
- EMG/NCV
- MYELOGRAM
- PAIN INJECTIONS

HAVE YOU EVER BEEN DIAGNOSED OR SUSPECTED OF HAVING CANCER?

HAVE YOU EVER HAD A MOTOR VEHICLE ACCIDENT? WHEN?

HAVE YOU EVER BEEN INJURED ON THE JOB BEFORE? WHEN?

**CHECK OFF ALL CONDITIONS THAT YOU MAY HAVE
CURRENTLY OR HAVE HAD IN THE PAST**

- | | | |
|---|---|---|
| <input type="checkbox"/> ATHRITIS
<input type="checkbox"/> ARTERIOSCLEROSIS
<input type="checkbox"/> ANEMIA
<input type="checkbox"/> ASTHMA
<input type="checkbox"/> ALCOHOLISM
<input type="checkbox"/> WEAKNESS OF MUSCLES
<input type="checkbox"/> HEAD TRAUMA
<input type="checkbox"/> SWELLING FEET
<input type="checkbox"/> BLOOD PROBLEMS
<input type="checkbox"/> DIABETES | <input type="checkbox"/> THYROID PROBLEMS
<input type="checkbox"/> HIGH BLOOD PRESSURE
<input type="checkbox"/> EPILEPSY
<input type="checkbox"/> GALL BLADDER
<input type="checkbox"/> LIVER
<input type="checkbox"/> INTESTINAL PROBLEMS
<input type="checkbox"/> DEPRESSION
<input type="checkbox"/> HEADACHES
<input type="checkbox"/> NECK PAIN
<input type="checkbox"/> NUMBNESS arms/legs | <input type="checkbox"/> ULCERS
<input type="checkbox"/> PAIN UPON URINATION
<input type="checkbox"/> BLOOD IN STOOLS
<input type="checkbox"/> DIFFICULTY SLEEPING
<input type="checkbox"/> VENEREAL DISEASE
<input type="checkbox"/> FEVER
<input type="checkbox"/> HEART ATTACK
<input type="checkbox"/> FAINTING
<input type="checkbox"/> WEIGHT LOSS
<input type="checkbox"/> STROKE |
| <p>DO YOU HAVE A PACEMAKER? (CIRCLE ONE)</p> | | |
| | | YES or NO |

AUTHORIZATION TO RELEASE INFORMATION

You are authorized to release any information you deem necessary concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof. **I have received the Notice of Privacy Practices (HIPPA) and I have been offered a copy of such.**

ACKNOWLEDGEMENT & UNDERSTANDING

I hereby acknowledge that I am receiving (or about to receive) health care services at **Dr. Christos Vasakiris, D.C., P.C.'s office** and that I have been advised that the doctor providing the services is willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made by insurance proceeds or out of the settlement of a liability claim. I understand that if it is determined that either:

- (a) There is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the doctor or make other provisions for the protection of the interest of the doctor, or
- (b) If the liability claim exists and my attorney refuses to agree to protect the doctor, or I have not engaged the services of an attorney:

then payment for the services rendered by the doctor at **350 West Montauk Highway Lindenhurst** will be made on a current and timely basis by myself and paid in full. I agree to take full responsibility for the outstanding balance.

I hereby give consent to Dr. Christos Vasakiris to administer any/all chiropractic services allowed under the scope of practice in New York State which he deems necessary in the treatment and diagnosis of my condition.

**PATIENT'S
SIGNATURE** _____

DATE _____

Christos Vasakiris, D.C.,D.A.C.A.N.

350 West Montauk Highway
Lindenhurst, N.Y , 11757

PLEASE PRINT

Patient Name _____ SS# _____

Address _____ City _____

State _____ Zip Code _____ Birth Date ____/____/____ Age _____

Circle one: Marital Status: S/M/D/W/P

How Did you find us? _____

Your Occupation _____ Years at this job _____

Your Employer's Name &
Address _____

Cell Phone (____) _____ Work Phone (____) _____

Home Phone # (____) _____

E-Mail Address: _____

MEDICAL PHYSICIAN'S NAME _____
ADDRESS _____

EMERGENCY CONTACT
NAME: _____ PHONE _____

If the patient is a minor, permission is hereby given to
the doctors in this office to perform an examination and
treatments. I am his/her legal guardian.

Parent Signature _____

INSURANCE INFORMATION: (choose one)

Medical Insurance company name: _____

Policy #: _____ Group #: _____

Insured person's name _____ SS#: _____

No-Fault Insurance Company: _____

Policy Number (Insurance Card) _____ Phone #: _____

Mailing Address _____

Worker's Compensation Carrier Name/Phone# _____

Claim # _____ Policy # _____ Date injured _____

Please answer all the following questions to the best of your ability.

WHAT IS YOUR MAJOR COMPLAINT? _____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

PLEASE DESCRIBE WHAT YOU FEEL IS THE CAUSE OF THIS COMPLAINT: _____

If Your Current Problem is from an AUTO ACCIDENT OR WORK Injury PLEASE SPECIFY:

WORK RELATED

AUTO RELATED

This Box For Auto & Work injury Only

Please specify the date and time of your injury: Date: _____ Time: _____ Location: _____

If this was a car accident, were you (circle one): DRIVER / PASSENGER in the: FRONT/ BACK of the car or A PEDESTRIAN

How long have you been working at your current job? _____ (circle one): FULL TIME or PART TME

Are you currently working? YES or NO Last Day worked: ____/____/____

TO WHOM WAS THE ACCIDENT REPORTED IF IT OCCURRED AT WORK? (ex. Supervisor) _____

Did you report this accident to your insurance company? YES or NO

Please specify exactly what tasks your job involves: _____

If you have been treated or seen by another Doctor or Hospital for this problem, please give us their name and address as well as what the doctor did for you and what they told you.

NAME OF DOCTOR: _____ SPECIALTY: _____

TREATMENT GIVEN: _____

SPECIAL TESTS (x-rays, etc.): _____

WHAT DID THEY SAY? _____

IS YOUR CONDITION GETTING: (circle one) WORSE BETTER SAME

WHAT HAVE YOU BEEN DOING FOR THIS INJURY AT HOME? _____

PRIOR TO THIS INJURY, HAVE YOU HAD A SIMILAR COMPLAINT? YES or NO

DO YOU NOTICE ANY ACTIVITY RESTRICTIONS TO YOUR DAILY ROUTINE SINCE THE INJURY? _____

HOW HAS THE PAIN AFFECTED YOUR SLEEP HABITS? _____

WHAT MAKES YOUR PAIN WORSE? _____

WHAT MAKES YOUR PAIN BETTER? _____

IS THERE ANY OTHER AREA OF YOUR BODY THAT CAUSES YOU PAIN? (circle one) YES or NO

If yes, where? _____

HAVE YOU EVER HAD A PREVIOUS MOTOR VEHICLE ACCIDENT OR JOB INJURY IN YOUR LIFE? (circle one) YES or NO If yes, when and how? _____



Draft

DC Patient Intake Form (version 1.1)

www.palladianhealth.com/members



Last name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

First name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)

1. Why are you here today? If there are many reasons, please choose only the most important or most severe one.

- | | | | |
|--------------------------------------|--------------------------------|-----------------------------|--------------------------------|
| <input type="radio"/> Neck | <input type="radio"/> Shoulder | <input type="radio"/> Hip | <input type="radio"/> Headache |
| <input type="radio"/> Upper/mid back | <input type="radio"/> Elbow | <input type="radio"/> Knee | <input type="radio"/> Other |
| <input type="radio"/> Lower back | <input type="radio"/> Wrist | <input type="radio"/> Ankle | |
| | <input type="radio"/> Hand | <input type="radio"/> Foot | |

2. When did this problem first begin?

- Less than 1 month ago 1-3 months ago 4-6 months ago 7-12 months ago More than 1 year ago

Has this problem...

No Yes

3. ... resulted from a work injury (i.e. workers' compensation insurance claim)?

4. ... resulted from a motor vehicle accident (i.e. no fault insurance claim)?

5. ... recently been evaluated by a medical doctor?

Since this problem began, have you noticed...

No Yes

6. ... so much weakness in both your arms that you are unable to lift them?

7. ... so much weakness in both your legs that you are unable to walk without help?

8. ... difficulty controlling your bowel or bladder, or have you been unable to urinate?

9. ... pain in your chest, shortness of breath, or coughing up blood?

10. ... that one leg felt more warm, more swollen, more red, or more tender than the other?

Have you recently...

No Yes

11. ... had blurred vision, double vision, dizziness, or fainting?

12. ... had any type of infection, fever, or chills?

13. ... had any type of surgery, surgical procedure, or medical procedure?

14. ... lost a lot of weight without really trying to (i.e. without being on a diet)?

15. ... had any type of accident, fall, or trauma?

Have you ever...

No Yes

16. ... been diagnosed with cancer?

17. ... been diagnosed with osteoporosis (i.e. weak, soft, or brittle bones)?

18. ... been diagnosed with a weakened immune system?

19. ... used any injected drugs (i.e. non-prescription drugs)?

20. ... used steroids such as prednisone for more than 4 weeks?

Is this problem something that ...

No Yes

21. ... you've had before?

22. ... generally gets worse (i.e. more severe or frequent) with movement, activity, or exercise?

23. ... generally gets better (i.e. less severe or frequent) with rest?

24. ... was recently examined with diagnostic imaging tests such as x-rays, MRI scan, or CT scan?

25. ... is also being treated by a health professional other than a chiropractor?

Service Date:

		/			/				
M	M		D	D		Y	Y	Y	Y

Draft





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PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)

Last Name																	First Name														
-----------	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	------------	--	--	--	--	--	--	--	--	--	--	--	--	--	--

1. In general, would you say your health is

Excellent	Very good	Good	Fair	Poor
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The following questions are about activities you might do during a typical day.
Does your health now limit you in these activities? If so, how much?

2. Moderate activities, such as moving a table,
pushing a vacuum cleaner, bowling, or playing golf

Yes, limited a lot	Yes, limited a little	No, not limited at all
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. Climbing several flights of stairs

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
-----------------------	-----------------------	-----------------------

During the past week, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

4. Accomplished less than you would like

All of the time	Most of the time	Some of the time	A little of the time	None of the time
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5. Were limited in the kind of work or other activities

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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During the past week, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

6. Accomplished less than you would like

All of the time	Most of the time	Some of the time	A little of the time	None of the time
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. Did work or other activities less carefully than usual

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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8. During the past week, how much did pain interfere with your normal work (including work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Extremely
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

These questions are about how you feel and how things have been with you during the past week.
For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past week...

9. Have you felt calm and peaceful?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. Did you have a lot of energy?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
-----------------------	-----------------------	-----------------------	-----------------------	-----------------------

11. Have you felt downhearted and depressed?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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12. During the past week, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How would you rate the severity of your main problem on a scale from 0 (not severe) to 10 (worst imaginable)?

	Not severe	0	1	2	3	4	5	6	7	8	9	10	Worst imaginable
13. Right now		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
14. On average		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
15. At its best		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
16. At its worst		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

Service Date: / /

M M / D D / Y Y Y Y

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PATIENT AUTHORIZATION
FOR THE USE AND DISCLOSURE
OF PROTECTED HEALTH INSURANCE

1. I, _____, hereby authorize Dr. Vasakiris to use and/or disclose to my insurance company, treating physicians, and/or attorney, the following specific protected health information: complete medical record unless otherwise informed.
2. I understand that this authorization is valid until I inform Dr. Vasakiris that this authorization is no longer valid.
3. I understand that the purpose or use of the disclosure I am granting is to protect my patient privacy and personal health information.
4. I expressly acknowledge that this authorization is voluntary.
5. The following is/are other criteria or limitations that I make regarding this authorization:

6. I understand that the office will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
7. I understand that this authorization may be revoked by the authorizer, in writing, at any time in accordance with the attached authorization revocation procedure. I also understand that the revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.
8. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.
9. I understand that my health care and payment for my healthcare will not be affected if I do not sign this form.
10. I understand that I may see and copy the information described in this form, if I ask for it, and that I will get a copy of this form after I sign it.
11. This form was completely filled in before I signed it. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its consents.
12. This authorization is valid as of ___/___/_____, the date I have signed below.

Name of Individual (Printed)

Signature of Individual

Date

Signature of Legal Representative

Relationship

PATIENT CONSENT
FOR USE AND/OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION
TO CARRY OUT TREATMENT, PAYMENT
AND HEALTHCARE OPERATIONS

_____ hereby states that by signing this consent, I acknowledge and agree as follows.
PATIENT NAME

1. The Practice’s Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosure of my protected health information (“PHI”) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out it’s health care operations. The Practice has further explained to me that the Privacy Notice will be available to me in the future upon my request. The Practice has further explained to my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing the Consent.
2. The Practice reserves the right to change it’s privacy practices that are described in it’s Privacy Notices, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the practice a) a postcard mailed to me at the address provided by me; and b) telephoning my home, cellular device or place of employment, and leaving a message on my answering machines or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and treatment provided to me) in order for the practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct it’s specific healthcare operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the practice is not required to agree to any restrictions that I have requested. If the practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven (7) years. I further understand that I have the right to revoke consent, in writing, at anytime for *all future* transaction, with the understanding that such revocation shall not apply to the extent that the practice has already taken action in reliance on this consent.
7. I understand that if I revoke consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will have the option not to treat me.

I have read and understand the forgoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed)

Signature of Individual Date

Signature of Legal Representative

Relationship