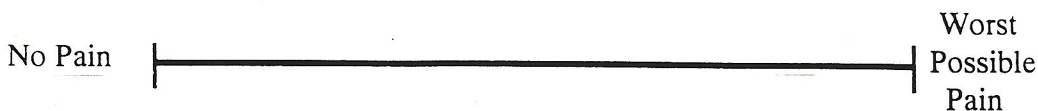
PAIN DRAWING

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
/\/\/\/\/\	========	OOOOOOOO	....	/////////	XXXX
/\/\/\/\	=======	OOOOOOO	....	///////	XXX



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

____
Patient Signature

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? ____________________________

PREVIOUS MEDICAL HISTORY

Smoker? Yes/No Packs/Day __________ Alcohol intake weekly_______________

Recreational Drugs (ever) Yes/No

Describe all surgeries

____

____

Describe all fractures ____

Describe all Medical Problems (Diabetes, 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

□ ATHRITIS	□ THYROID PROBLEMS	□ ULCERS
□ ARTERIOSCLEROSIS	□ HIGH BLOOD PRESSURE	□ PAIN UPON URINATION
□ ANEMIA	□ EPILEPSY	□ BLOOD IN STOOLS
□ ASTHMA	□ GALL BLADDER	□ DIFFICULTY SLEEPING
□ ALCOHOLISM	□ LIVER	□ VENEREAL DISEASE
□ WEAKNESS OF MUSCLES	□ INTESTINAL PROBLEMS	□ FEVER
□ HEAD TRAUMA	□ DEPRESSION	□ HEART ATTACK
□ SWELLING FEET	□ HEADACHES	□ FAINTING
□ BLOOD PROBLEMS	□ NECK PAIN	□ WEIGHT LOSS
□ DIABETES	□ NUMBNESS arms/legs	□ STROKE
DO YOU HAVE A PACEMAKER? (CIRCLE ONE)		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 of 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.

NO-FAULT ASSIGNMENT: I hereby authorize and direct you to pay the above physician out of any monies that may now or hereafter become payable to me for my benefit, from you as the responsible No-Fault insurance carrier.

PATIENT'S SIGNATURE ___________________________________ **DATE** _________________

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

______________________ hearby 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 extend 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**