Questionnaire

please answer all questions completely

Dear patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name _____ Sex_____ Marital Status _____ DOB _____

Home Phone_____ Address _____ City_____ State _____

Zip_____ Occupation_____

Social Security # _____ Business Phone _____ Company Name _____

Spouse's First Name_____ Spouse's Soc, Sec, # _____ Spouse's Employer _____

Please explain in detail how your accident happened _____

_____

_____

_____

What were the time and date of present injury?_____
Where did you feel pain immediately after the accident?_____
List the extent of your injuries as you know them:_____

_____

_____

Did you require post accident hospitalization? Yes No

Circlo symptoms you have noticed since the accident:

Headache	Dizziness	Depression	Fatigue
Stomach Upset	Light Bothers Eyes	Buzzing in Ears	Diarrhea
Neck Pain	Head Seems Too Heavy	Loss of Memory	Feet Cold
Neck Stiff	Pins & Needles in Arms	Ears Ring	Hands Cold
Fainting	Sleeping Problems	Loss of Balance	Back Pain
Face Flushed	Pins & Needles in Legs	Constipation	Tension
Nervousness	Numbness in Fingers	Loss of Smell	Fever
Irritability	Numbness in Toes	Loss of taste	Chest Pain
Cold Sweats	Shortness of Breath	_____	_____

Symptoms other than above:_____

_____

Where were you taken after the accident?_____
Hospitalized? Yes No If yes, admitted? _____ **How Long?** _____
Name of Hospital _____
Name of doctors _____
What treatment was given? _____
Was any other doctor consulted after your accident? ◯Yes ◯No
If so, what was the doctor's name? _____ **D.C., M.D., D.O., D.D.S**
What was the diagnosis? _____

JAMAICA CHIROPRACTIC &
PHYSICAL THERAPY PLLC
144-31 JAMAICA AVENUE
JAMAICA, NY 11435

Functional capacity checklist.

Please indicate your degree of pain while performing the following activities on a scale of 0 (No pain) to 10 (severe pain) or **N.Y.P.** (Not yet performed)

Sleeping	
Lying on black	
Lying on side	
Lying on stomach	
Sitting	
Standing	
Bending	
Lifting	
Kneeling	
Pulling	
Pushing	
Twisting	
Crawling	
Going up/down stairs	
Carrying	
Dressing/undressing	
Showering/bathing	
Putting shoes/socks/bra/shirt/pants on/off	
Cooking	
Food shopping	
Laundry	
Sweeping	
Typing	
Walking	
Running	
Sports	
Exercising	
Intimate relations	
Other	
Other	
Other	

Signature _____

Date _____

Balance Self Test

Are You At Risk For Falls?

Patient Name: _____ SSN: _____

1. Have you fallen more than once in the past year? ◯ YES ◯ NO

2. Do you lose balance when standing still, or
   When you initially get up after sitting? ◯ YES ◯ NO

3. Does it take you more than one try to get out of a chair or out of bed? ◯ YES ◯ NO

4. Do you lose your balance or feel unsteady when walking? ◯ YES ◯ NO

5. Do you get dizzy, faint or have seizures? ◯ YES ◯ NO

6. Do you trip over your own feet or objects on the floor? ◯ YES ◯ NO

7. Do you take corners too sharp and bump into corners or door frames? ◯ YES ◯ NO

8. Do you use a walker, cane or need assistance to get around? ◯ YES ◯ NO

9. Have you had a recent loss or decrease in, vision or hearing? ◯ YES ◯ NO

10. Do you have numbness or loss of sensation in your feet or your legs? ◯ YES ◯ NO

11. Have you experienced a stroke or any other health problems
that may have affected your balance? ◯ YES ◯ NO

If you answered YES to one or more questions, you may have a balance problem. If you are concerned about falling, or simply want to take a balance test please speak to your physician.

NCV/SSR self Test

Patient Name: _____

1. Do you suffer from neck pain, with pain in your arms and legs? YES ◯ NO ◯
2. Do you have weakness, numbness, or burning in either your arms or your hands? YES ◯ NO ◯
3. Do your hands or arms fall asleep? YES ◯ NO ◯
4. Do you have reduced feeling (sensation) in your hands or arms? YES ◯ NO ◯
5. Do you suffer from loss of hand grip strength? YES ◯ NO ◯
6. Do you suffer from back pain with pain in your buttocks, legs, or feet YES ◯ NO ◯
7. Do you have weakness, numbness, or burning in your buttocks, legs, or feet? YES ◯ NO ◯
8. Do your legs or feet fall asleep? YES ◯ NO ◯
9. Do you have reduced feeling (sensation) in your buttocks, legs, or feet? YES ◯ NO ◯
10. Do you have a pacemaker? YES ◯ NO ◯

If you answered YES then you are **not allowed** to take this test!!

If you answered YES to one or more questions, please speak with your physician about having this test preformed.

JAMAICA CHIROPRACTIC & PHYSICAL THERAPY, PLLC. 144-31
JAMAICA AVE. JAMAICA, NY 11435
P: 718-206-3369
F: 855-201-6872
Jcptl 4431@gmail.com
Jamaicalnjurydoc@gmail.com

Thank you for taking your time and filling out this questionnaire about your prior health history including events not related to this accident. The more we know about you the better we will be able to serve you. Filling this questionnaire out completely will save you approximately I hour of your time in our office. Dr. Long

How did your accident happen?

_____

_____

_____

Previous treatment for this accident (Please circle):

1. Hospital/ family doctor/ therapy facility/ Other
Date:
Name of facility:

2. Hospital/ family doctor/ therapy facility/ Other
Date:
Name of facility:

3. Hospital/ family doctor/ therapy facility/ Other
Date:
Name of facility:

Please list any x-rays, CT scans, MRIs that were performed and to what body part. Also list the which facility which performed them.

_____

_____

Please list any medications which were given to you, prescribed to you recommended for you as a result of this accident. Please list the medication name, who prescribed it and what you are taking it for:

_____

_____

Please list any procedures or injections which were performed for this current accident and which facility listed performed then.

_____

_____

Please advise if you have lost any time from work as a direct result of your injuries from this accident.

- ◯ Yes
- ◯ No

At work as a direct result of your injuries:

- ◯ I am unable to perform all of my tasks at work
- ◯ I am able to perform all of my tasks at work

Please list all of your prior:

Motor vehicle accidents NOT related to this accident. (year, body parts injured, approximately date of last treatment and if resolved)

1.

2.

3.

Work accidents NOT related to this accident. (Year, body parts injured, approximately date of last treatment and if resolved)

1.

2.

3.

Surgeries related to this accident (please list year, body part, approximate date of last treatment and if resolved)

1.

2.

Prior surgeries NOT related to this accident (please list year, body part and if resolved)

1.
2.
3.
4.
5.

Please list any past history of any major medical condition you currently have or have been previously diagnosed with in the past (Include past heart, lung, kidney, liver G.I, high blood pressure, high cholesterol, stroke, vascular or neurological conditions) Please list year diagnosed and condition.

1.
2.
3.
4.
5.

Medications you are currently taking as a direct result of this accident. Please list medication name, who prescribed it and what you were taking it for. (also include any non-prescription medication)

1.
2.
3.
4.
5.

Medications you are currently taking NOT because of this accident. Please advise what condition you are taking this medication for.

1.
2.
3.
4.
5.

Jamaica Chiropractic & Physical Therapy PLLC

144-31 Jamaica Avenue

Jamaica, NY 11435

SMS Text Message Consent Form:

Jamaica Chiropractic & Physical Therapy PLLC would like to offer the ability to receive text message, fax and/or email reminders for your appointments at our office and offices in which we refer you to. In the near future, we are also planning to send other health information out by electronic means, such as informing you that test results are in, or that we need to get in touch with you. We might also occasionally send information about other services that we feel may be important to you.

In addition, you grant our office the ability to contact other healthcare providers and your attorney via text, fax or email regarding your treatment and/or legal case. By signing below I CONSENT to the practice contacting me, my attorney or other healthcare providers by text message fax or e-mail for the purpose health information and appointment reminders. I will ensure that I keep the practice informed of my up to date mobile number at all times, or if the number is no longer in my possession. I agree that I can revoke my consent at any time and will do so via certified mail.

Patient Name:	
Date of Birth:	
Mobile Number:	
Signature:	
Today's Date:	

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPPA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent: and or verbally discussed via telephone Jamaica Chiro practice and Physical Thera PLLC 144-31 Jamaica Ave Jamaica NY 1 1435 TIN 82-4340696 NPI 157825616

9.(a). Specific information to be released:

- ⇨ Medical Record from (insert date) _____ to (insert date) _____
- ⇨ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ⇨ Other: _____
  _____

Include: (Indicate by Initialing)

_____ Alcohol/Drug Treatment

_____ Mental Health Information

_____ HIV-RELATED Information

Authorization to discuss Health Information

(b) ⇨ By initialing here_____ I authorize _____

Initials — Name of individual health care provider

To discuss my health information with my attorney, or a governmental agency, listed her:

_____

(attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ⇨At request of individual ⇨Other:	11.Date or event on which this authorization will expire:
12. If not the patient, name of person signing from:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provide a copy of the form.

_____ **Date**: _____

signature of patient or representative authorized by law.

☆ **Human Immunodeficiency Virus that causes AIDS. The New York State Health Law protects information which reasonably could identify someone as having HIV symptoms or infection & information regarding a person's contacts.**