CONFIDENTAL
PATIENT CASE HISTORY

HERALD SQUARE CHIROPRACTIC & SPORT

Name _____ DOB _____

Home _____ Age _____

Address _____ # of children _____

_____ Marital Status S M D W

Work # _____ Spouse's Name _____

Home # _____ Spouse's Phone _____

E-mail _____

Employer _____ Referred by: _____

SS # _____

HEALTH INFORMATION

What is your major complaint? _____

Other complaints: _____

How long have you had this condition (approximate date)? _____

Have you had this or similar conditions in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? ❑ YES ❑ NO ❑ CONSTANT ❑ COME & GOES

Is this condition interfering with your: ❑ WORK ❑ SLEEP ❑ DAILY ROUTINE ❑ OTHER _____

How long has it been since you really felt good? _____

Other doctors who treated this condition: _____

List surgical operations and years: _____

_____

Drugs you now take: ❑ NERVE PILLS ❑ PAIN KILLERS ❑ MUSCLE RELAXERS ❑ "PEP" PILLS

❑TRANQUILIZERS ❑INSULIN ❑ BIRTH CONTROL ❑ OTHER _____

Age of mattress _____ ❑ COMFORTABLE ❑ UNCOMFORTABLE

Are you wearing: ❑ HEEL LIFTS ❑ SOLE LIFTS ❑ INNER SOLES ❑ ARCH SUPPORTS

Have you been in an auto accident? ❑ PAST YEAR ❑ PAST 5 YEARS ❑ OVER 5 YEARS ❑ NEVER

Describe _____

Medical History

HERALD SQUARE CHIROPRACTIC & SPORT

Past Medical History

- ❑ Alcoholism
- ❑ Allergies
- ❑ Anemia
- ❑ Asthma
- ❑ Anxiety Disorder
- ❑ Arthritis
- ❑ Asthma
- ❑ AIDS/HIV
- ❑ Back Problems
- ❑ Bleeding Disorder
- ❑ Blood Disease
- ❑ Blood Transfusion
- ❑ Cancer
- ❑ Diabetes
- ❑ Depression
- ❑ Ear Problems
- ❑ Eating Disorder
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart Disease
- ❑ Heart Problems
- ❑Hepatitis – A, B, or C
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Joint Disorder
- ❑ Kidney Disorder
- ❑ Liver Disorder
- ❑ Lung Disease
- ❑ Measles
- ❑ Migraine
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Rheumatic Fever
- ❑ Stroke
- ❑ Thyroid Disorder

Other: _____

Family Medical History

- ❑ Alcoholism
- ❑ Allergies
- ❑ Anemia
- ❑ Asthma
- ❑ Anxiety Disorder
- ❑ Arthritis
- ❑ Asthma
- ❑ AIDS/HIV
- ❑ Back Problems
- ❑ Bleeding Disorder
- ❑ Blood Disease
- ❑ Blood Transfusion
- ❑ Cancer
- ❑ Diabetes
- ❑ Depression
- ❑ Ear Problems
- ❑ Eating Disorder
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart Disease
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- ❑ Kidney Disorder
- ❑ Liver Disorder
- ❑ Lung Disease
- ❑ Measles
- ❑ Migraine
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Rheumatic Fever
- ❑ Stroke
- ❑ Thyroid Disorder

Other: _____

Hospitalizations & Surgeries

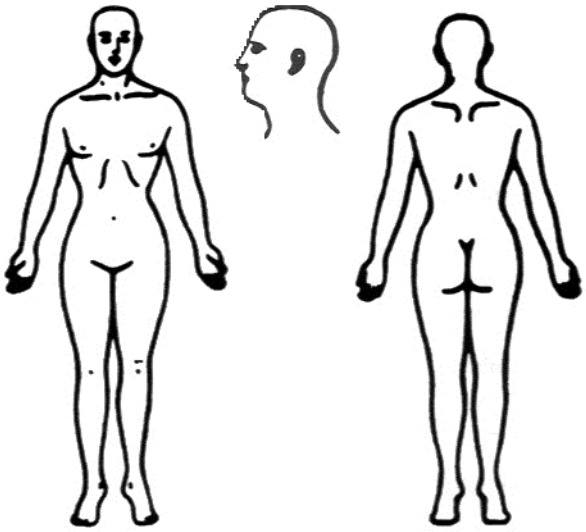
Reason: _____ Date: _____

Reason: _____ Date: _____

Reason: _____ Date: _____

Date of Last Physical Examination _____

HERALD SQUARE CHIROPRACTIC & SPORT



Have you suffered from?

1.	Dizziness	❑ Yes	❑ No
2.	Backaches	❑ Yes	❑ No
3.	Heart trouble	❑ Yes	❑ No
4.	Diabetes	❑ Yes	❑ No
5.	Arthritis	❑ Yes	❑ No
6.	Headaches	❑ Yes	❑ No
7.	Asthma	❑ Yes	❑ No
8.	Neuritis	❑ Yes	❑ No
9.	Digestive disorder	❑ Yes	❑ No
10.	Nervousness	❑ Yes	❑ No
11.	Sinus trouble	❑ Yes	❑ No
12.	Neck Pain	❑ Yes	❑ No

INSURANCE INFORMATION

Is your condition due to an accident or job related injury? ❑ Yes ❑No

Do you have health insurance? ❑ Yes ❑No

Name of Company _____ Policy # _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Medical Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Medical Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date _____

Guardian or Spouse Signature: _____ SS # _____

Doctor's Signature: _____ Date _____

ASSIGNMENT/DIRECT PAYMENT TO DOCTOR
PRIVATE/GROUP ACCIDENT and HEALTH INSURANCE

HERALD SQUARE CHIROPRACTIC & SPORT

PATIENT: _____

EMPLOYER: _____

GROUP NO: _____

SSN/ID: _____

I hereby instruct and direct my insurance company to pay by check made out and mailed to:

Herald Square Chiropractic & Sport
45 W 34th St. Suite 903
New York, NY 10001

If policy provisions prohibit direct payment to physician, I hereby also instruct and direct you to make out the check to me and mail to the address above. Payment is for the professional or medical expense benefits allowable, and otherwise payable, to me under my current insurance policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in current manner, any balance of said professional services charges over and above this insurance payment. A photocopy of this Agreement of Rights and Benefits shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

_____ _____

DATE Signature of Policy Holder

_____

Witness

Herald Square Chiropractic & Sport

45 W 34th St. Suite 903
New York, NY 10001
(646)454-8264

HIPAA PRIVACY NOTICE
(effective 4/14/03)

This notice describes how medical information about you may be used and disclosed and how you may obtain access to this information. In 1996, Congress as part of the (HIPAA) Health Insurance Portability and accountability Act, orders that a set of rules be established to control how health information is used and disclosed, as maintained by doctors, hospitals, and health plans. Health information is considered sensitive and personal, and the law establishes consumer protection and limits the sharing of such information, as do similar protections already enacted for bank accounts, credit cards, and even video rentals.
This office has always recognized the importance of privacy; this new federal law formalizes practices that have been followed routinely.

By law, consent is not required to discuss your medical treatment with your other doctors or health care providers. This allows, also for prescription to be called into your pharmacy and for scheduling of surgery in a hospital.

Additionally, none is needed in the course of carrying out health care operations, such as quality assessment, or in communication with your insurance carrier for payment related issues, or for incidental uses, such as announcing a name in a waiting room or the use of sign-in sheets.

However, this office has always gone one step further in protecting you and does not believe in releasing specific information about you to any business or governmental entity without your written consent.

Specific authorization is required to disclose protected information in a non-routine circumstance, such as to your employer or for use in marketing a product to you.

Medical information about you may be released for research and public health uses, as long as you are not individually identified.

You are guaranteed access to review your medical record, and you may amend the record if you believe it to be incomplete or inaccurate.

You have the right to review when and to whom your information was released.

You may suggest additional restrictions with regard to certain issues and disclosures, if you wish.

Portions of this notice may be modified, as long as you are notified.

Should you believe that your privacy rights have been compromised, you may report the violation, without penalty to you, to this office or to the Secretary of Health.

The law requires that you acknowledge receipt of this notice; this has been included on the signature release on your registration form.

Acknowledgement:

Patient name: _____

Signature: _____ Relationship to patient: _____ Date: _____

Patient's Pregnancy Evaluation Form

(For female patients only)

HERALD SQUARE CHIROPRACTIC & SPORT

Dear Patient,

In order for us to fully evaluate you we are required to take some x-rays of some part(s) of your body. It has been predicted that an unborn child in the first trimester would be more sensitive to radiation than an adult. In order to insure that accidentally, knowingly or otherwise, no Fetus (unborn child) be exposed to radiation from x-ray machines, we ask you to provide us with the following information. We thank you for the information and this information is strictly confidential and is solely used for the purpose it is indented.

Date: _____

Name: _____

Date of the onset of last menstrual period: _____

Is there any chance that you may be pregnant? ❑ Yes ❑No

To the best of my knowledge, I am not pregnant and by providing this application for Physician/Technologist has informed me of the effects of Radiation to the Unborn baby and me by signing below have consented to taking the x-rays of my body parts for further studies.

Signature:_____

Herald Square Chiropractic & Sport

Chris B. Cueto, DC, CCSP
45 W 34th St. Suite 903
New York, NY 10001
(646)454-8264

Informed Consent for Chiropractic Treatment

I hereby request and consent to the performance of consultation, evaluation, chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostics x-rays on me (or on the patient named below, for who I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office.

I further understand that such chiropractic services may be performed by the physicians of Herald Square Chiropractic & Sport who may treat me now and in the future at this office. I have had the opportunity to discuss with the physicians the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks of treatment: including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interest at the time, based upon the facts then known.

I have read, or have read to me, the above consent. I have also had the opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of my treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

_____
Print Patient's Name

_____
Signature of Patient

_____
Date

To be completed by the patient's representative, if necessary, (eg: if the patient is a minor or is physically or mentally incapacitated):

_____
Print Patient's Name

_____
Print Name of Representative

_____
Signature of Representative

This form should be maintained in the patient's health record.

COMPLEMENTARY NUTRITION CONSULTATION *(optional)*

HERALD SQUARE CHIROPRACTIC & SPORT

Name: _____ Date: _____ Age: _____
Address: _____ City: _____ State: _____ Zip: _____
Email address: _____ Phone number: _____

As a patient at Herald Square Chiropractic & Sport you are entitled to a 30 minute health and wellness consultation with a certified nutrition counselor to review your health goals and any concerns in greater detail. Are you interested in a free nutrition consultation? ❑ Yes ❑No

1. Please indicate the areas of health that you want to improve:

   ❑ Lose weight ❑Boost energy ❑Sleep better ❑Improve digestion ❑Improve blood work

   ❑ Prevent problems ❑ Reduce stress ❑Reduce acid reflux ❑ Improve general health

   Other: _____

2. If you could improve ONE thing about your health, please specify below.

   _____

3. Do you exercise? _____ If so, what type, frequency, duration? _____

4. How many hours of sleep do you get on average each night? _____

   Problems sleeping? ❑ Yes ❑No

5. Do you take any nutritional supplements? ❑ Yes ❑No

   If yes, please list: _____

6. Do you consume? ❑ Coffee or tea How many cups per day? _____

   ❑ Soda or juice How many cups per day? _____

   ❑ Alcohol How many drinks per week? _____

7. Do you have any dietary restrictions or food allergies/sensitivities? Please list.

   _____

Any other concerns?

We look forward to supporting you and your wellness goals!