EPSTEIN FAMILY
WELLNESS CENTER
The power that made the body, heals the body...
1 Dorothea Street Plainview, NY 11803 | **Call: (516) 932-1616**

PATIENT INFORMATION & CONDITION FORM Chart Number________

Personal Information

Name: _________________________________ Today's Date: ____/____/____

Social Security# _________________________ Birth Date: _____/_____/______ Age: ______ Gender: ☐ M ☐ F

Street: ____

City: _______________________________________ State: ___________ Zip: _____________________

Ethnicity: ☐ White ☐ Hispanic or Latino ☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ Other

Home Phone (_______) _______________________ Email Address ___________________________

Cell Phone (_______) ____________________ Cell Phone Carrier ________________________

Contact Preference: ☐ Home ☐ Cell ☐ Text Message ☐ Email

Primary Care Doctor _______________________ Phone Number (_______) __________________

Your Occupation __________________________________ Employer ________________________

Work Address __________________________________ Work Phone (______) ________________

Student at ____ ☐ FULL-TIME ☐PART TIME

Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Single

Name of Spouse ___________________________________ Spouse's Date of Birth ____/____/____

Name of Emergency Contact _____________________ Phone (_____) ______________________

Address: ____

Current Health Condition

How Did You Find Out About Our Practice? ____

What is The Reason For Your Visit Today? ____

Other Doctors Seen For This Condition ☐ Yes ☐ No Who? __________________________________

Type of Treatment: _______________________ Results: _______________________________________

When Did Your Condition Occur? _______________ Has This Condition Occurred Before? ☐Yes ☐No

What treatments have you tried & have they been effective? ____________________________

How long has it bothered you? 1 2 3 4 5 6 7 ☐ Days ☐ Weeks ☐ Months ☐ Years

Is Condition: ☐ Job Related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other: _________________________

Date of Accident: ______________________ Time of Accident:________________________________

Have You Made A Report of Your Accident To Your Employer: ☐ Yes ☐ No

Past Health History

Please Check And Describe:

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery

☐ Broken Bones ☐ Other ____

Major Accident or Falls: ____

Hospitalization (Other than Above):____

____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name & Approximate Date of Last Visit_________________

Insurance Information

Primary Insurance: _______________________________________

Insured Information:

Subscriber Name: ___________________ Relationship to Insured: ☐ Spouse ☐ Child ☐ Self ☐ Other ________

Phone #: (______) ________________ Sex: ☐ M ☐ F

Address: ____

Policy ID: ________________ Group ID: _______________ Employer: ______________

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

INTAKE

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

Have you been tested HIV positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

NERVOUS SYSTEM CODE

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

GENERAL CODE

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R CODE

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT CODE

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

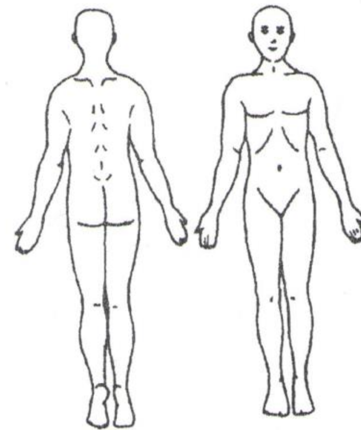
MALE/FEMALE CODE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems
- ☐ ______________________
- ☐ ______________________
- ☐ ______________________

FEMALES ONLY:

When was your last period?_______

Are you pregnant?
☐ Yes ☐ No ☐ Not Sure



Please outline on the diagram the area of your discomfort.

FAMILY HISTORY

The following members have a same or similar problem as I do:

- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child

DO NOT WRITE BELOW THIS LINE

ANALYSIS:

DIAGNOSIS:

Patient Accepted: ☐ Yes ☐ No ☐ Referred

____
Doctor's Signature

Health History

Medications

Name	Date Started	Taken For?	Dosage	Frequency	Route (Oral, Injection)	Given By

Allergies

Type of Allergy	Reaction

Major Illnesses (Diabetes, High Blood Pressure, ETC)

Date (Approx)	Illness

Social History

Martial Status	Lives (Alone, Spouse, Etc)	Caffeine (Per Day)	Alcohol (None, Casual, Heavy)	Drug Use (None, Recreational, Addiction)	Exercise (Never, Daily, Weekly, Etc)

Smoking Status

Never	Former	Current Every Day Smoker	Current Some Day Smoker