PATIENT INTAKE FORM

Today's Date ____/___/____

Full Legal Name _____ **How do you prefer to be addressed?**_____

Date of Birth _____/_____/_____ **Age**_____ **Single**___ **Married**___ **Widow**___ **Divorced**____

Social Security _____-_____- _____ **E-mail Address**_____

Home Phone _____-_____-_____ **Mobile Phone** _____-_____-_____

Street Address _____ **City** _____ **State** ____ **Zip Code** _____

Who referred to our office? _____

Emergency Contact _____**Phone Number** _____-_____-_____ **Relationship** _____

Primary Care Physician Name_____ **Phone Number** _____-_____-_____

Your occupation _____ **Years at current occupation** _____

Employer's Name _____ **Work Phone #** _____-_____- _____ **Ext. #** _____

Have you ever/or currently have:

- ☐ Headaches
- ☐ Neck Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Pins/ Needles in Arms
- ☐ Pins +Needles in Legs
- ☐ Numbness in Fingers
- ☐ Numbness in Toes
- ☐ Pain in the Arms
- ☐ Pain in the Legs
- ☐ Pain between Shoulders
- ☐ Hands Cold
- ☐ Feet Cold
- ☐ Neck Stiff
- ☐ Back Stiff
- ☐ Chest Pain
- ☐ Face Flushed
- ☐ Shortness of Breath
- ☐ Dizziness
- ☐ Convulsions
- ☐ Eyes Sensitive to Light
- ☐ Loss of Memory
- ☐ Ringing in the Ears
- ☐ Fainting Cold Sweats
- ☐ Loss of Balance
- ☐ Chronic Cough
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Diarrhea
- ☐ Constipation
- ☐ Stomach Upset
- ☐ Poor Digestion
- ☐ Tension
- ☐ Irritability
- ☐ Fatigue
- ☐ Depression
- ☐ Nervousness

Yes No

- ☐ ☐ Been Knocked Unconscious?
- ☐ ☐ Used Crutches or other Support?
- ☐ ☐ Been Treated for Spine Problems?
- ☐ ☐ Been Treated for any Nerve Disorder?
- ☐ ☐ Had a Fractured/Broken Bone?
- ☐ ☐ Had surgery or been hospitalized?

Please List _____

Is there a Family History of?

- ☐ Heart Disease
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Stroke
- ☐ _____

Medications currently being taken

1. _____ 3. _____
2. _____ 4. _____

Your Current Problem

What are you current symptoms? 1. _____2. _____ 3. _____ 4. _____

What level of intensity would you rate your pain? (10=severe) ***1 2 3 4 5 6 7 8 9 10***

What is the frequency of your symptoms? ***Occasional / Episodic / Intermittent / Frequent / Constant***

Do your symptoms affect your personal life? (hobbies, sports, etc) _____

Do your symptoms affect your job /occupation? (missed days, inability to stand, sit, lift, drive) _____

How long have you suffered from these symptoms? _____Have you suffered from these symptoms before? ☐ Yes ☐ No

What makes your symptoms worse? _____What makes your symptoms better? _____

What home remedies have you tried? _____

Have you been to another doctor for this problem? _____Chiropractic care before? ☐ No ☐Yes Who? ____

Patient Acknowledgement

By my signature, I understand and acknowledge that DeSano Chiropractic and Vitality Center, its Physicians and agents, will treat my condition as they deem necessary through the use of Chiropractic Manipulative Therapy and adjunctive therapies. I also understand that all original documents and original x-rays created as a result of the performance of examinations will remain the property of DeSano Chiropractic and Vitality Center, its Physicians and agents, will not be held responsible for any undisclosed pre-existing conditions. As the parent, guardian or parentally authorized agent, I hereby authorize DeSano Chiropractic and Vitality Center, its Physicians and agents, to administer care to this minor.

Signature of Patient (responsible person) _____ Date: ____/_____/____

DeSano Chiropractic and Vitality Center

84-16 Jamaica Avenue
Woodhaven, NY 11421
718-296-6900

Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name_____ Birthday_____

Signature_____ Date_____

Authorization to Release Medical Information

I authorize Dr. _____ to release any medical information pertinent to my treatment to an authorized representative for review. This authorization for release of information shall remain valid for the term of my coverage under my current policy. I certify that all insurance information given to this clinic is correct and complete. I also know that I am entitled to receive a copy of this authorization form.

Patient's Signature _____ Date___/___/___ Witness_____

Request for Payment of Benefits to Provider of Care

I hereby authorize the _____ Insurance Company/ Insurance Administrator to pay by check, and for it to be mailed directly to: 84-16 Jamaica Avenue Woodhaven, NY 11421 the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patient's Signature_____ Date___/___/___ Witness_____

Dr. Anthony S. DeSano. D.C.
DeSano Chiropractic and Vitality Center

INFORMED CONSENT AND ARBITRATION AGREEMENT

The nature of the Chiropractic Adjustment: The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument on your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles.

Analysis / Examination / Treatment: As part of the analysis, examination, and treatment, you are consenting to the following procedures: spinal manipulative therapy, basic orthopedic and neurological testing, muscle strength testing radiographic studies and/or hot/cold therapy, electrotherapy or ultrasound. Other (please explain) _____

The material risks inherent in Chiropractic Adjustment: As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: burns, rash, fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications. Some patients will feel stiffness and soreness following the first few days of treatment.

The probability of those risks occurring: Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. The incidences of vascular accident are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The availability and nature of other treatment options: Other treatment options for your condition may include: Self administered analgesics and rest - Medical care and prescription drugs - Hospitalization and or Surgery. If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers to remaining untreated: Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by New York State law, and not by lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it are giving up their right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Anthony S. DeSano and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

_____ _____

Print Name **Date**

_____ _____

Signature **Signature of parent or Guardian (If patient is a minor)**

Dr. Anthony S. DeSano
84-16 Jamaica Avenue
Woodhaven, NY 11421

Electronic Health Records Intake Form

In compliance with requirements for the government EHR program

First Name:_____ **Last Name**:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐**I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____ /_____