SIROTA CHIROPRACTIC OFFICES

NAME: ______________________________ DATE: ______________

ADDRESS: ____________________ PHONE: (   ) _____-______ ALT PHONE (   ) ____-______

CITY: __________ STATE: ___ ZIP: _____ OCCUPATION: ______________ SS.#: ____-____-______

EMPLOYER: ______________ AGE: ___ D.O.B.: __/__/__ SEX: M / F MARTIAL STATUS: M S W D

ADDRESS: ______________ CITY: __________ STATE: _____ ZIP: ______-______

Email: ______________

IS YOUR CONDITION DUE TO AN ACCIDENT OR ILLNESS? YES NO

DID YOUR ACCIDENT OCCUR AT WORK? YES / NO WHEN? ______________

AUTO ACCIDENT? YES / NO WHEN? ______________

WERE YOU HOSPITALIZED? YES / NO WHERE? ______________

DESCRIBE BRIEFLY HOW THE ACCIDENT OCCURED? ______________

____

____

____

SYMPTOMS

HEAD:
- __HEADACHE
  - __ENTIRE HEAD/TOP OF HEAD
  - __BACK/FRONT OF HEAD
  - __TEMPLES
- __HEAD FEELS HEAVY
- __MEMORY LOSS/LAPSE
- __LIGHT HEADEDNESS
- __FAINTING
- __DIZZINESS
- __BALANCE DISTURBANCE
- __LOSS OF SMELL
- __LOSS OF TASTE
- __LOSS OF HEARING
- __EAR PAIN (R / L)
  - __RINGING (R / L)
  - __BUZZING (R / L)

NECK:
- __NECK PAIN ANYTIME
- __PAIN UPON MOVEMENT
- __PINCHED NERVE
- __STIFF NECK
- __MUSCLE SPASMS
- __GRINDING/POPPING SOUNDS
- __FEELS OUT OF PLACE
- __ARTHRITIS ?

MID-BACK:
- __PAIN
- __SHARP STABBING PAIN
- __PAIN BETWEEN SHOULDER BLADES
- __SPASMS

CHEST:
- __PAIN
- __SHORTNESS OF BREATH
- __PAIN AROUND RIBS
- __ANGINA

ABDOMEN:
- __PAIN
- __NAUSEA
- __GAS
- __DIARRHEA/CONSTIPATION

LOW BACK:
- __PAIN
- __PAIN WORSENS WHEN ?
  - __WORKING
  - __LIFTING/BENDING
  - __STOOPING
  - __SITTING/ARISING
  - __STANDING/WALKING
  - __LYING DOWN/ARISING
  - __COUGH / SNEEZE
  - __PINCHED NERVE
  - __SLIPPED DISC
  - __FEELS OUT OF PLACE
  - __SPASMS
  - __ARTHRITIS ?

ARMS & HANDS:
- __PAIN WITH USE (R / L / BOTH)
- __PAIN ANYTIME
  - __FOREARM/ELBOW (R /L / BOTH)
  - __HAND/WRIST (R / L/ BOTH)
  - __FINGERS (R / L / BOTH)
- __TINGLING
  - __FOREARM/ELBOW (R / L / BOTH)
  - __HAND/WRIST (R / L / BOTH)
  - __FINGERS (R / L / BOTH)
- __SORENESS
  - __FOREARM/ELBOW (R / L / BOTH)
  - __HAND/WRIST (R / L / BOTH)
  - __FINGERS (R / L / BOTH)
- __NUMBNESS
  - __FOREARM/ELBOW (R / L / BOTH)
  - __HAND/WRIST (R / L / BOTH)
  - __FINGERS (R / L / BOTH)
- __ARTHRITIS ?
- __LOSS GRIP STRENGTH (R/L/BOTH)
- __PINCHED NERVE
- __COLD (R / L / BOTH)

WOMEN:
- __INCREASED MENSTRUAL PAIN
- __CRAMPING (ABDOMEN / BACK)
- __IRREGULARITY
- __HEAVY BLEEDING

SHOULDERS:
- __PAIN (R / L)
- __ACROSS SHOULDERS
- __TENSION BETWEEN SHOULDERS
- __SPASMS
- __PINCHED NERVE (R / L)
- __UNABLE TO RAISE ARM (R / L / BOTH)
  - __TO SHOULDER LEVEL (R / L / BOTH)
  - __OVER-HEAD (R / L / BOTH)
- __BURSITIS ? (R / L / BOTH)
- __ARTHRITIS ? (R / L / BOTH)

HIPS, LEGS, & FEET:
- __PAIN
  - __BUTTOCK (R / L / BOTH)
  - __HIP (R / L / BOTH)
  - __LEG (R / L / BOTH)
- __PINS & NEEDLES SENSATION
- __TINGLING IN LEG (R / L / BOTH)
- __NUMBNESS
- __LEG (R / L / BOTH)
  - __FEET (R / L / BOTH)
  - __TOES (R / L / BOTH)
- __CRAMPING IN FEET (R / L)
- __SWELLING
  - __ANKLE (R / L / BOTH)
  - __FEET (R / L / BOTH)
- __COLDNESS IN FEET (R / L / BOTH)
- __CRAMP IN LEG (R / L / BOTH)
- __JOINT PAIN
  - __KNEE (R / L / BOTH)
  - __ANKLE (R / L / BOTH)
  - __TOES (R / L / BOTH)

GENERAL:
- __NERVOUSNESS
- __IRRITABILITY
- __DEPRESSED / ANXIOUS
- __TIRED
- __INSOMNIA
- __UNKNOWN WEIGHT LOSS/GAIN
- __LOSS OF/ INCREASED APPETITE
- __LOSS OF/ INCREASED SLEEP
- __GENERALLY RUN-DOWN / FATIGUE

SYMPTOM CHECKLIST

THIS IS A LIST OF DIFFICULTIES AND FEELINGS WHICH PEOPLE SOMETIMES HAVE AFTER AN INJURY. PLEASE INDICATE WHICH ONES YOU HAVE EXPERIENCED RECENTLY BY PLACING AN "X" UNDER THE "YES" COLUMN AND INDICATE WHICH ONES YOU HAVE NOT EXPERIENCED BY PLACING AN "X" UNDER THE "NO" COLUMN. PLEASE INDICATE WHICH SYMPTOMS YOU DID AND DID NOT EXPERIENCE BOTH BEFORE AND AFTER YOUR RECENT INJURY. THANK YOU!

	Have you experienced these after your injury?		Did you experience these before your injury?	
SYMPTOMS	YES	NO	YES	NO
Often feel unwell.				
Have blackouts or seizures.				
Sometimes start to put clothes on backwards.				
Sometimes knock things over.				
Often have headaches.				
Have trouble remembering things.				
Find difficulty in becoming interested in anything.				
Often lose temper.				
Have felt unwanted.				
Feel the need to keep things tidy.				
Sometimes suffer from noise inside the head.				
Often feel anxious or tense.				
Suffer from dizziness.				
Suffer from ringing in the ears.				
Have difficulty concentrating when reading.				
Have been in trouble with the law.				
Sometimes bump into things.				
Talk too much.				
Very easily affected by alcohol.				
Sometimes lose way, despite have been there many times before.				
Have difficulty hearing.				
Have lost sense of taste and/or smell.				
Have difficulty with eyes.				
Often troubled by too much noise.				
Have difficulty following a conversation.				
Have lost interest in life.				
Have difficulty speaking.				
Occasionally hear voices inside head.				
Often irritable.				
Refuse to admit difficulties.				
Have had a nightmare in the last two weeks.				
Often feel restless.				
Have difficulty holding a conversation.				
Become tired very easily.				
Sometimes laugh for no reason at all.				
Often impatient.				
Sometimes behave childishly.				

FAMILY HISTORY

DO YOU OR DOES ANYONE OF YOUR FAMILY HAVE ANY OF THE FOLLOWING ILLNESSES?

DIABETES:	[ ] SELF	[ ] MOTHER	[ ] FATHER	[ ] SISTER	[ ] BROTHER
HIGH BLOOD PRESSURE:	[ ] SELF	[ ] MOTHER	[ ] FATHER	[ ] SISTER	[ ] BROTHER
ASTHMA:	[ ] SELF	[ ] MOTHER	[ ] FATHER	[ ] SISTER	[ ] BROTHER
ULCERS:	[ ] SELF	[ ] MOTHER	[ ] FATHER	[ ] SISTER	[ ] BROTHER
EPILEPSY:	[ ] SELF	[ ] MOTHER	[ ] FATHER	[ ] SISTER	[ ] BROTHER
MENTAL ILLNESS:	[ ] SELF	[ ] MOTHER	[ ] FATHER	[ ] SISTER	[ ] BROTHER
AUTOIMMUNE DISEASE:	[ ] SELF	[ ] MOTHER	[ ] FATHER	[ ] SISTER	[ ] BROTHER

DO YOU DRINK ALCOHOL? YES / NO APPROX. NUMBER OF DRINKS PER WEEK? ______________

DO YOU SMOKE CIGARETTES? YES / NO APPROX. HOW MANY PACKS PER DAY? ______________

DO YOU DO DRUGS? YES / NO

PREVIOUS MEDICAL HISTORY

HAVE YOU EVER HAD A SERIOUS MEDICAL PROBLEM OR ILLNESS? YES / NO

IF YES, DESCRIBE?

____

____

HAVE YOU EVER HAD ANY PREVIOUS ACCIDENTS OR FALLS? YES / NO

IF YES, DESCRIBE?

____

____

BROKEN BONES OR DISLOCATIONS? YES / NO

IF YES, DESCRIBE?

____

____

PREVIOUS OPERATIONS? YES / NO

__TONSILECTOMY DATE: __________ __APPENDECTOMY DATE: __________

__GALL BLADDER DATE: __________ __CARDIAC DATE(S): __________

__BACK SURGERY DATE: __________ __RECTAL SURGERY DATE: __________

__HERNIA(S) DATE(S): __________ __THYROID DATE: __________

__FEMALE ORGANS DATE: __________ __C-SECTION(S) DATE(S): __________

__ OTHER ______________ DATE _____ ___ OTHER ______________ DATE ______

DO YOU TAKE ANY MEDICATIONS? YES / NO

IF YES, WHAT?

____

HAVE YOU EVER HAD ANY SPINAL TAPS OR SPINAL INJECTIONS? YES / NO

HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS? YES / NO

LOSS OF MEMORY? YES / NO

HAVE YOU EVER HAD X-RAY PICTURES MADE OF YOUR CASE? YES / NO

IF YES, BY WHOM AND FOR WHAT?

____

____

NOTE: IT IS UNDERSTOOD AND AGREED THAT ANY X-RAYS OR OTHER IMAGING STUDIES TAKEN OR ORDERED BY THIS OFFICE WILL REMAIN THE PROPERTY OF THIS OFFICE. THEY MAY BE SEEN AS PER THE HIPAA REGULATIONS.

SIGNATURE: ______________________________ DATE: ______________

INSURANCE INFORMATION

FOR THIS ACCIDENT/ILLNESS, WHAT INSURANCE (IF ANY) IS TO BE USED?

[ ] MAJOR MEDICAL [ ] WORKERS' COMPENSATION [ ] NO-FAULT [ ] MEDICARE/-AID

[ ] GHI [ ] CASH [ ] OTHER ______________________

NAME OF PATIENT/CLAIMANT: ______________ NAME OF INSURED: ______________

NAME OF INSURANCE COMPANY: ______________________

ADDRESS: ______________ CITY: ______________ STATE: ______ ZIP: ______

INSURANCE COMPANY PHONE #: ______________ EXAMINER: ______________ EXT: ______

IF CAR ACCIDENT/NO-FAULT:

CLAIM #: ______________ POLICY #: ______________ EXAMINER: ______________

IF WORKERS COMPENSATION:

W.C.B. #: ______________ CARRIER CASE #: ______________ EXAMINER: ______________

IF MAJOR MEDICAL:

POLICY #: ______________ GROUP #: ______________ EFFECTIVE DATE: ______

IF MEDICARE/-AID: MEDICARE #: ______________ MEDICAID#: ______________

IF GHI/HIP:

POLICY #: ______________ GROUP #: ______________

IF OTHER:

POLICY #: ______________ GROUP #: ______________

NAME OF ATTORNEY

FIRM NAME: ______________________

ATTORNEY NAME: ______________________

TELEPHONE #: ______________ FAX#: ______________

ADDRESS: ______________ CITY: ______________ STATE: ______ ZIP: ______

REFERAL INFORMATION

REFERED BY: ______________

Patient Consent for
Use and Disclosure of Health Information

Jonathan A. Sirota, DC, CCSP
8 Cottage Place White Plains, NY 10601
Mailing Address: 18 West Haviland Lane Stamford, CT 06903
914-437-8781 Fax 914-437-8783

By signing, I authorize Sirota Chiropractic Center to use and/or disclose my protected health information (PHI) to carry out treatment, payment activities and healthcare operations.

I understand I have the right to read the Notice of Privacy Practices before I decide whether to sign this Consent. The Notice provides a description of treatment, payment activities, and healthcare operations, the uses and disclosures Sirota Chiropractic Center may make of my protected health information, and of other important matters about my protected health information. A copy of the Notice accompanies this Consent and I am encouraged to read it carefully and completely before signing this Consent.

I understand that Sirota Chiropractic Center reserves the right to change their privacy practices as described in the Notice of Privacy Practices. If they change their privacy practices, they will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of my protected health information that they maintain.

I understand that at any time I may obtain the most recent version of the Notice of Privacy Practices by contacting:

Contact Officer: **Dr. Jonathan A. Sirota**
Telephone: **914-437-8781** Fax: **914-437-8783**
Email: Doc@DrSirota.com Address: P.O.Box 340628 Brooklyn, N.Y. 11234

I understand that I have the right to refuse to sign this consent. Sirota Chiropractic Center will not condition my treatment (and, if applicable, payment for my health care or eligibility for benefits) on whether I provide authorization for the requested use of disclosure – except in limited circumstances. (e.g. if the treatment is research-related or is necessary for the purpose of creating protected health information for disclosure to a third party.)

I understand that I have the right to revoke this Consent in writing by sending my revocation to the Contact Officer listed above. I understand that revocation of this Consent will not affect any action(s) taken by Sirota Chiropractic Center before they received my written revocation.

I understand this authorization will expire on: 01/01/2099

I, ______________________________, have had full opportunity to read and consider the content of this Consent and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information in order to carry out treatment, payment activities and health care operations.

Signed by: ______________________________ ______________
Signature of Patient or Legal Guardian Date

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ______________________________

Relationship to Patient: ______________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.