Dr. Stuart Weitzman
BEDFORD HILLS
FAMILY CHIROPRACTIC

PATIENT INFORMATION

Name_____ Today's Date _____

Street Address_____ City _____ State_____ Zip _____

Age _____ Date of Birth _____ Social Security # _____ Height _____ Weight _____

E-mail address _____

Phone H(_____) _____ Cell (_____) _____Work (____) _____

Marital Status S M D W L/W Significant Other Name of Spouse _____

Names and Ages of Children_____

Occupation_____ Employer_____

Emergency contact (name-Relationship)_____ (Where they could be reached)_____

Whom may we thank for referring you to our office? _____

√ were you referred by __ Insurance Co. __ Our Website __ By our Location __ Found us in the Phone book __ Other

Insurance Co. _____ Policy #_____ Policy Holder_____

What type of treatment are you seeking? **Circle** all that apply: *Chiropractic Care, Traditional Adjustments, Pediatric Care Activator/Arthrostim Instrument Adjustments, Webster Technique for Pregnancy, Cranial Sacral, ART, SASTM, Graston, KinesioTaping, Gait Analysis, Injury care, Sports/Performance Care, Training For an Event/Race, Wellness Care*

What concern/complaints bring you to the office? _____

Date this problem began? _____ and was it ____Sudden ____Gradual ____Progessive over time (Please √ **)**

Do you know how It started or what brought it on? _____

Where is the pain or problem exactly? _____

√ Type of Pain/Symptoms __ Dull __ Ache __Sharp __Burning __Stabbing __Throbbing __ Cramping __ Swelling __Numbness
__ Tingling ___ Pins/Needles ___ Other _____ (Please Describe)

√ Does the pain or symptoms radiate into your ___ Arms (L / R / Both) ___ Legs (L / R / Both) ___ Does not radiate (L / R / Both)

√ Is the pain or problem __ Constant __ Frequent __ Occasional __ Intermittent __ Rarely

How would you rate your problem on a scale of 1-10 (10 is the WORST) ____ Currently ____ at your best ___at your worst

What makes your symptoms/condition worse? _____

What relieves your symptoms/condition ? _____

√ Do your symptoms interfere with ___ Work ___ Sleep ___ Day to Day Activity ___ Recreation ___ Home/Family Life

What have you done to make your condition better (Medications, OTC, Hot, Cold, Rest, stretching, massage) _____

_____

Have you seen any other Heathcare Provders for this condition?_____

_____

Did they prescribe any medications specifically for this condition?_____

HEALTH HISTORY

Who is your Internal Medicine Doctor or MD you see most regularly? _____ Last seen _____

Are you being treated for any health conditions by any Doctors currently ? _____

Do you take any Prescription medications for other conditions No / Yes Which ones _____

Please list all Supplements (vitamins/herbal supplements/homeopathics/others) you are taking:_____

_____

Would you be interested in recommendations for nutritional supplements to help your current condition or other health issues? Yes / No

Have you had any problems in the ***past or presently*** with any of the following parts of the body or these conditions? Please √

__Heart	__Lungs	__Thyroid	__Kidneys	__Liver	__Pancreas	__Stomach
__Esophagus	__Intestines	__Bladder	__Ovaries	__Sex Organs	__Sinuses	__Throat
__Gall Bladder	__Eye	__Ears	__Nose	__Blood Disorders (i.e. Anemia, Clotting disorders)		
__Diabetes	__ Influenza	__Fibormyalgia	__MS	__Osteoporosis/penia		__ Rheumatoid Arthritis
__Heart Disease	__Stroke	__High Blood Pressure		__Atherosclerosis		__ Paralysis
__Cancer	__Asthma	__COPD/Emphysema		__Sinus Infections		__ Allergies
__**Headaches/Migraines**	__OCD	__Depression		__Anxiety		__ Diverticulitis/osis
__Colitis	__Ulcers	__Reflux		__Crohn's		__ Hypo/Hyperthyroid
__Seizures	__Dizziness	__Ringing in ears		__Diarrhea		__Constipation

Please list all past Surgeries:

Type_____ When _____ Doctor/Hospital_____
Type_____ When _____ Doctor/Hospital_____
Type_____ When _____ Doctor/Hospital_____
Type_____ When _____ Doctor/Hospital_____

Please list all previous broken bones / accidents / falls/ injuries/ hospitalizations:

What_____ When _____ Injuries _____
What_____ When _____ Injuries _____
What_____ When _____ Injuries _____
What_____ When _____ Injuries _____

Current Health Behaviors:

Do you smoke/use tobacco? Yes / No How much?_____
Alcohol/Drug use Yes/ No Please explain (Casual, Social, regularly) _____
Do you exercise? Yes/ No What /How often? _____
On a scale of 0-10 describe your stress level (0=none / 10=extreme): Occupational _____ Personal _____
On a scale of Poor-Good-Excellent describe your : Diet _____ Exercise _____ Sleep _____ Physical Health _____
Emotional/Mental Health _____ Quality of Life _____

Family History:	Diabetes	Cancer	Heart Disease	Stroke	Description
Father-living Yes/No	☐	☐	☐	☐	_____
Mother-living Yes/No	☐	☐	☐	☐	_____
Brother(s) # of __	☐	☐	☐	☐	_____
Sister(s) # of __	☐	☐	☐	☐	_____
Adoption History of __	☐	☐	☐	☐	_____

For Women:

Are you pregnant? Yes No Date of last menstrual period: _____
If x-rays are recommended, your signature is required (below) to indicate that you are not pregnant.
Signature and Date:_____

If pregnant, what is due date? _____ Name of OB/GYN or Midwife _____
Where will you be birthing your baby? ❑ Hospital ❑ Home ❑ Birthing Center ❑ Other_____

Chiropractic / Other Healthcare Providers:

Previous Chiropractic care? Yes / N With whom_____
How long under care? _____Date of last visit: _____Why did you stop? _____
Was there a particular health concern for which you consulted the chiropractor? _____
Have you consulted or do you regularly consult any of the following providers? (please √ all that apply)___Naturopath ___Acupuncturist ___Homeopath ___Massage Therapist ___Psychotherapist ___Energy Healer ___Other _____
Who and Why_____
_____

Wellness Objectives

At Bedford Hills Family Chiropractic, we are dedicated toward achieving the goal of total lasting health for all of our patients. To better understand your individual health objectives, please check all that apply that are the closest to your personal health goals:

❑ Symptom/Temporary Relief ❑ Restore Health ❑ Maximum Correction ❑ Wellness & Prevention ❑ Improved Performance

What are your expectations? As a result of my Chiropractic Care, I would like to: (Check all that apply)

❑ Feel better quickly ❑ Have a healthier nerve system ❑ Have a healthier spine ❑ Have optimum health on all levels

Financial Information

Payment in full is expected on all FIRST VISIT services. All other fees are to be paid at time of service unless other arrangements have been made and agreed upon in writing.

Please read the following and sign below.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare my necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my treatment, any fees for professional services rendered me will be immediately due and payable.
I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of the office, being on file where they may be seen at any time while I am an active patient in this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions not for any medical diagnosis. Patient may obtain copies of their file upon request. Copying fees may apply.

The information I have provided, on this case history form, is true and accurate, to the best of my knowledge. I give Dr. Stuart Weitzman permission to render care to me today. This initial visit includes a health history/consultation, chiropractic exam/evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

*Signature*_____ *Today's Date*_____
*Signature of Parent (for minor):*_____ *Today's Date*_____

Thank you for choosing Dr. Stuart Weitzman of Bedford Hills Family Chiropractic.
We look forward to helping you achieve your health and wellness goals so you can *express your life to the fullest*.

HIPPA Awareness Form

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. IF you would like a detailed copy of our Notice of Privacy Practices, we will gladly provide it to you upon request.
By signing this you understand and agree that your Personal health information (PHI) will be used in the following ways:
For Treatment: We may use and disclose your PHI to any healthcare provider to assist them in treating you.
For Payment: We may use and disclose your PHI for payment purposes.
Correspondence: We may call your home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out typical practice operations (TPO). We may mail to your home or other designated location any items that assist the practice in carrying out typical practice operations TPO, as long as they are marked personal and confidential. We may also, email you at home or other designated location any items that assist the practice in carrying out TPO. Items that may assist the practice include but not limited to: appointment reminder cards and patient statements.
You have a right to:

- Look at or get a copy of your health information. You must make your request in writing.
- Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
- Request additional restrictions on our use disclosure of your medical information. We are not required to agree to theses additional restrictions, but if we do so, we will abide by our agreement (except in case of emergency).
- Request that we communicate with you by different means or to different locations. Your request must be made in writing to our privacy officer.
- Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons.

Acknowledgement Form

I have reviewed the above information and have been given the opportunity to read the detailed Notice of Privacy Practices if I requested to do so.
Signature_____ Date_____
Patient or Legal Guardian (if a minor)

Authorization to Pay Doctor

I hereby authorize the _____ (Insurance Company) to pay by check made out and mailed directly to:

Bedford Hills Family Chiropractic, PC
Stuart Weitzman, D.C.
85 Adams Street
Bedford Hills, NY 10507

The expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment shall not exceed my indebtedness to above named assignee and I have agreed to pay, in a current manner, any balance of said professional services charges over and above this insurance payment.

Patient Name_____

Address_____

City/State/ Zip _____

Signature & Date_____