Spoke to:	Date:	Time:	Oral Consent to examine/treat child: Y N	Initials:

Dr. Leslie Dreifus & Dr. Robin Wieder
Chiropractors
1201 Avenue J Brooklyn NY 11230
718-377-6363

Date:_____

Patient History

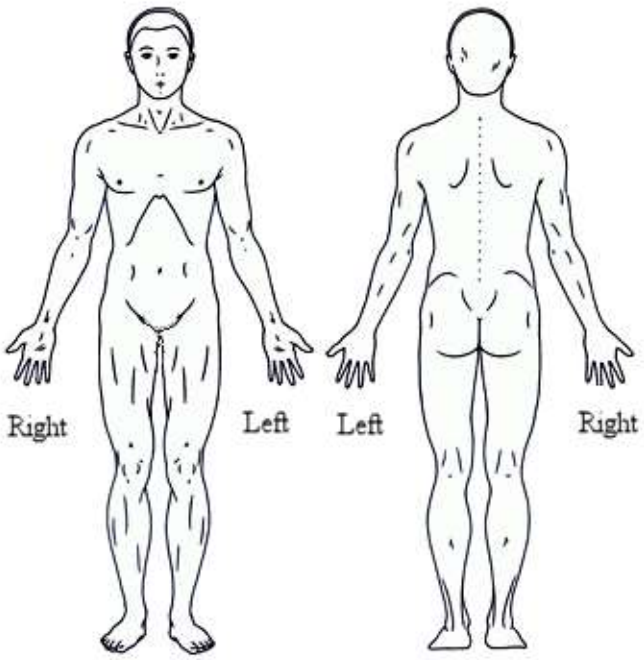
Name_____Sex: M__F__Birthdate_____
Address_____City_____State_____ Zip_____
H. Phone (_____)_____Cell #:_____ W. Phone_____ Email:_____
Referred by_____Social Security #_____Occupation:_____
Employer/School_____Address:_____
Marital Status S M D W Spouse Name_____# of children_____
Emergency Contact:_____ Relationship to patient:_____ Cell.Ph#_____
Home Ph#_____Work #_____
Primary Health Insurance:_____Name of Insured_____ID#_____
Secondary Health Insurance:_____Name of Insured_____ID#_____
Have you ever received Chiropractic Care? Yes_ No_

Please circle for each of the following:		Patient Comment If answer is Yes	Chiropractor's Comments
1. Growth and Development/ Childhood:			
Childhood illnesses?	Y N	_____	_____
Drugs, prescription, OTC, recreational?	Y N	_____	_____
Surgery?	Y N	_____	_____
Hospitalizations?	Y N	_____	_____
Sports or other physical activities	Y N	_____	_____
Injuries during sports?	Y N	_____	_____
Auto accidents?	Y N	_____	_____
Did you have other traumas?	Y N	_____	_____
Did you ever break any bones?	Y N	_____	_____
2. Current Health Habits:			
Did/do you smoke?	Y N	_____	_____
Did/do you drink alcohol?	Y N	_____	_____
Diet, do you eat healthy foods?	Y N	_____	_____
Have you been in accidents/trauma?	Y N	_____	_____
Have you had surgery?	Y N	_____	_____
Drugs, prescription, OTC, recreational?	Y N	_____	_____
Dental problems?	Y N	_____	_____
Eye problems?	Y N	_____	_____
Hearing problems?	Y N	_____	_____
Exercise regularly?	Y N	_____	_____
Did/do you have occupational stress?	Y N	_____	_____
Drive? Daily time spent driving	Y N	_____	_____
Physical stress?	Y N	_____	_____
Emotional/Mental stress?	Y N	_____	_____
Hobbies/Sports injuries?	Y N	_____	_____
Do you sleep well, hours of sleep?	Y N	_____	_____
Sleeping posture? O side O stomach O back		_____	_____

Symptoms and Present State of Health

Present Complaint/Reason for Seeking Care in this Office:
Major_____
Car accident? Y_N_ Work Accident? Y_N_
Pain or Problem started on_____
Pains are: O Sharp O Dull/ Ache O Constant O Intermittent O Other_____
Does this pain shoot, radiate, or travel in your body? Where?_____
Are you experiencing numbness or tingling in any area of your body? Where?_____
Since it began, is it: O Same O Better O Worst
What activities aggravate your condition/pain?_____
What activities lessen your condition/pain?_____
Is this condition worse during certain times of the day?_____
Is this condition interfering with Work?_____ Sleep?_____Routine?_____Other?_____
Is this condition progressively getting worse?_____
Other Doctors seen for this condition_____
Any home remedies? _____

Please Circle where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)
Using the symbols below, mark on the pictures where you feel pain.



Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other _____	^ ^ ^

Please mark any of the following conditions or symptoms that you have now or have experienced:
Other Symptoms:

O Headaches	O Pain in Hands or Arms	O Chest Pains
O Neck Pain	O Numbness in Hands or Arms	O Heart Attack
O Sleeping Problems	O Pain in Legs or Feet	O High Blood Pressure
O Low Back Pain	O Numbness in Legs or Feet	O Stroke
O Nervousness	O Fatigue	O Cancer
O Tension	O Depression	O Painful Urination
O Irritability	O Lights Bother Eyes	O Diabetes
O Dizziness	O Loss of Memory	O Diarrhea
O Pain Between Shoulders	O Shoulder Pain	O Constipation
O Neck Stiff	O Sinus	O Stomach Upset
O Joint Swelling	O Shortness of Breath	O Heartburn/Reflux
O Fever	O Asthma	O Weight Loss
O Loss of Balance	O Allergies	O Loss of Smell or Taste
O Ringing in Ears	O Cold Hands	O Menstrual Cramps
O Jaw/TMJ Problems	O Cold Feet	O Menopause

Are you under medical care for any condition?_____
What Medications are you taking?_____
How long?_____ Have you had surgery?_____ What?_____ When?_____
What side effects have you experienced from the drugs and surgery?_____
Females Only – Date last Menstrual Period began on_____ Are you possibly Pregnant?_____

Is there a family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other_____
Father's side	O	O	O	O	O
Mother's side	O	O	O	O	O

Assign and Release:

I hereby authorize my insurance benefits to be paid to this practitioner. I also authorize the release of any information required.
I hereby give permission for insurance payments to be made directly to the above provider. If I fail to provide the appropriate insurance information, referrals if required, and information requested to the above office, I will be held responsible and agree to pay for all fees incurred by this office.
I hereby acknowledge that I have received and reviewed the Privacy Notice posted in this office and all of my questions have been answered in the language that I can understand. I consent to the uses and disclosures described in the Privacy Notice.

Consent to Treat:

Diagnosis, prognosis & treatment protocols and effects and risks thereof have been described and I understand and am informed of such information. I hereby give consent to such treatment as described by the doctor. I understand and am informed that, as in all health care, in the practice of chiropractic there are some risks to treatment. This level of risk is most often very minimal and rare. These rare cases may include but not be limited to strain/sprain injuries, disc irritation, skin irritation, and fracture. Health history, physical examination provided prior to care to be discussed with doctor. Chiropractic care may include spinal manipulation, the use of modalities such as ultrasound, electric muscle stimulation, supportive/therapeutic taping/strapping, manual massage/trigger point therapy and rehabilitative care such as exercise.
I intend this consent to apply to all my present and future chiropractic care.

Patient/Parent or Guardian:_____Date:_____ Dr's signature:_____