Steven L. Weiner, DC PA
Care Chiropractic Center

NAME: First: _____ Last: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____

DATE OF BIRTH: _____ AGE: _____

SEX: ○ Male ○ Female STATUS: ○ Single ○ Married ○ Widowed ○ Minor
Spouse's Name: _____

CONTACT INFO: e-mail: _____
*Your e-mail is not shared with any third parties

Phone: Cell (____) _____ Home (____) _____ Work (____)_____

OCCUPATION: _____ Employer: _____

EMERGENCY CONTACT: Name: _____
Relationship: _____ Phone: (____) _____

REFERRED BY: _____

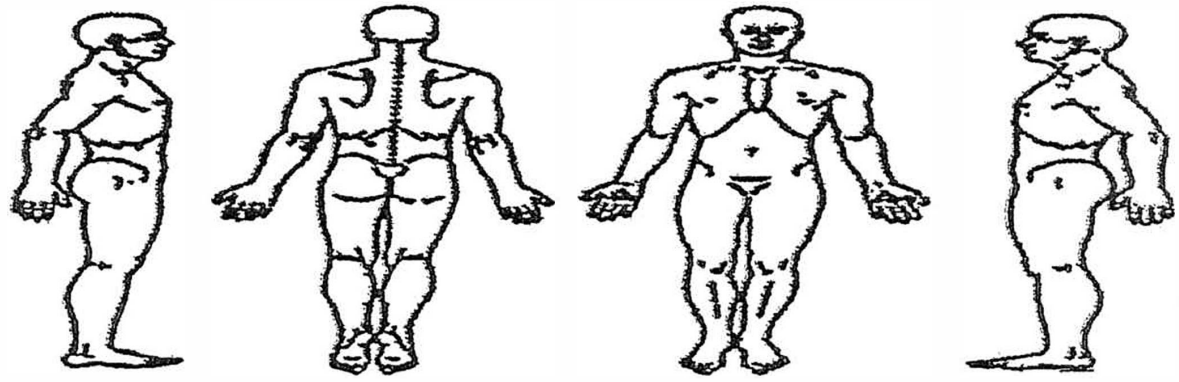
_____ _____
Signature of Patient, Parent or Guardian Date

Please limit cell phone calls in the waiting room.

PATIENT INTAKE FORM

Name: _____ Date: _____

1. Is today's problem caused by: ☐ Auto Accident ☐ Work Injury ☐ Other _____
2. Indicate on the drawings below where you have pain/symptoms (Darken area of symptoms)



3. How often do you experience your symptoms? (Check one)
   - ☐ Constantly (76 - 100% of the time)
   - ☐ Frequently (51 - 75% of the time)
   - ☐ Occasionally (26 - 50% of the time)
   - ☐ Intermittently (1 - 25% of the time)
4. How would you describe the type of pain? (Check all that apply)
   - ☐ Sharp
   - ☐ Dull
   - ☐ Achy
   - ☐ Stiff
   - ☐ Burning
   - ☐ Constant Shooting
   - ☐ Diffuse
   - ☐ Numb
   - ☐ Tingling
   - ☐ Other _____
   - ☐ Shooting with motion
   - ☐ Electric like with motion
   - ☐ Stabbing with motion
   - ☐ Sharp with motion
5. How are your symptoms changing with time?
   - ☐ Getting Worse
   - ☐ Staying the Same
   - ☐ Getting Better
6. Using a scale from 0 - 10, how would you rate your problem? (Circle one)
   (NO PAIN) ○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 (WORST PAIN)
7. How much has the problem interfered with your work? (Check one)
   - ☐ Not much
   - ☐ A little bit
   - ☐ Moderately
   - ☐ Quite a bit
   - ☐ Extremely
8. How much has the problem interfered with your social activities? (Check one)
   - ☐ Not much
   - ☐ A little bit
   - ☐ Moderately
   - ☐ Quite a bit
   - ☐ Extremely
9. Who else have you seen for your problem? _____
10. What have you tried to relieve this problem? Did it work? _____

_____

11. How long have you had this problem? _____
12. How do you think this problem began?

_____

13. What aggravates your problem?

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. How would you rate your overall health? (Check one)
    - ☐ Excellent
    - ☐ Very Good
    - ☐ Good
    - ☐ Fair
    - ☐ Poor
16. Please check one ... Are you right-handed? _____ or left-handed? _____

16. What type of exercise do you do? (Check one)

○ Strenuous ○ Moderate ○ Light ○ None

17. Do you drink coffee? Y N Cups per day? _____ Alcohol? Y N Drinks per day? _____ per week? _____

18. Do you smoke? Y N If so, how much per day? _____

19. Indicate if you have any immediate family members with any of the following: (Check all that apply)

○ Rheumatoid Arthritis ○ Diabetes ○ Lupus
○ Heart Problems ○ Cancer ○ ALS

20. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
○	○	Headaches	○	○	High Blood Pressure	○	○	Diabetes
○	○	Neck Pain	○	○	Heart Attack	○	○	Excessive Thirst
○	○	Upper Back Pain	○	○	Chest Pains	○	○	Frequent Urination
○	○	Mid Back Pain	○	○	Stroke	○	○	Smoking/Tobacco Use
○	○	Low Back Pain	○	○	Angina	○	○	Drug/Alcohol Dependence
○	○	Shoulder Pain	○	○	Kidney Stones	○	○	Allergies _____
○	○	Elbow/Upper Arm Pain	○	○	Kidney Disorders	○	○	Depression
○	○	Wrist Pain	○	○	Bladder Infection	○	○	Systemic Lupus
○	○	Hand Pain	○	○	Painful Urination	○	○	Epilepsy
○	○	Hip Pain	○	○	Loss of Bladder Control	○	○	Dermatitis/Eczema/Rash
○	○	Upper Leg Pain	○	○	Prostate Problems	○	○	HIV/AIDS
○	○	Knee Pain	○	○	Abnormal Weight Gain/Loss			
○	○	Ankle/Foot Pain	○	○	Loss of Appetite			
○	○	Jaw Pain	○	○	Abdominal Pain	For Females Only		
○	○	Joint Pain/Stiffness	○	○	Ulcer	○	○	Birth Control Pills
○	○	Arthritis	○	○	Hepatitis	○	○	Hormonal Replacement
○	○	Rheumatoid Arthritis	○	○	Liver/Gall Bladder Disorder	○	○	Pregnancy
○	○	Cancer	○	○	General Fatigue			
○	○	Tumor	○	○	Muscular Incoordination			
○	○	Asthma	○	○	Visual Disturbances			
○	○	Chronic Sinusitis	○	○	Dizziness			
○	○	Other						

21. List all prescription medications you are currently taking:

_____

_____

22. List all of the over-the-counter medications you are currently taking:

_____

23. List all surgical procedures you have had:

_____

24. What activities do you do at work? Sit?_____ Stand? _____ Other? _____ How long? _____

25. What activities do you do outside of work?

_____

26. Have you ever been hospitalized? ○ No ○ Yes If yes, why?

_____

27. Have you had significant past trauma? ○ No ○ Yes _____

28. Anything else pertinent to your visit today? _____

Patient Signature _____ Date _____

Steven L. Weiner, DC PA
Care Chiropractic Center

Insurance Company: _____
Subscriber Name: _____ Subscriber DoB: _____
ID# _____ Group# _____

Who is responsible for this account: _____

I authorize payment of my medical insurance benefits to Steven L. Weiner, DC , PA.

I understand it is my responsibility to be aware of my health insurance coverage.

I understand my health insurance coverage will only pay for services that it determines are "reasonable and necessary". If my health carrier determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, the insurer will deny payment for that service.

I am financially responsible for any charges/balance not covered by my health carrier.

I understand that prices and benefits quoted at the time of registration are good faith estimates and do not guarantee payment from my health insurance company.

I authorize the use of any medical information that might be necessary for my medical care or in processing my medical claims.

I understand that payment of deductibles, coinsurance and/or co-payment is due at the time of treatment.

I will follow-up promptly with additional information requested by my insurance company to process my claims.

By signing below, I acknowledge that I have read and agree to the above.

_____ _____

Signature of Patient, Parent or Guardian Date

Steven L. Weiner, DC, PA

Patient Consent for Use and Disclosure of Protected Health Information
And Receipt of Notice of Privacy Practices Acknowledgement Form

I hereby give my consent for Steven L. Weiner, DC, PA to use and disclose protected health information (PHI) about me to carry out treatment and healthcare operations (TPO).

Steven L. Weiner, DC, PA's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Steven L. Weiner, DC, PA, reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Steven L. Weiner's Privacy Officer at 8025 West McNab Road, Tamarac, FL 33321.

With this consent, Steven L. Weiner, DC, PA, may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying our TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results, among others.

With this consent, Steven L. Weiner, DC, PA may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders cards and patient statements.

With this consent, Steven L. Weiner, DC, PA, may e-mail to my home or other alternative location ay items that assist the practice in carrying our TPO, such as appointment reminders and patient statements. I have the right to request the Steven L. Weiner, DC< PA, restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Steven L. Weiner, DC, PA's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke Steven L. Weiner, DC, PA may decline to provide treatment to me.

I have read a copy of Steven L. Weiner, DC, PA's Notice of Privacy Practices.

_____ _____

Signature of Patient or Legal Guardian Date

_____

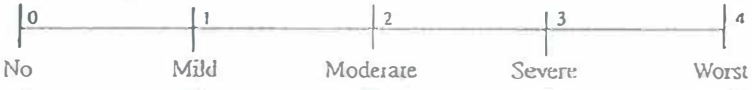
Print Name of Patient

Functional Rating Index

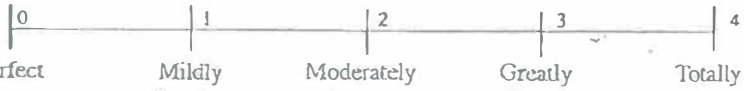
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

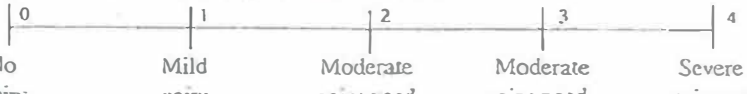
1. Pain Intensity



2. Sleeping

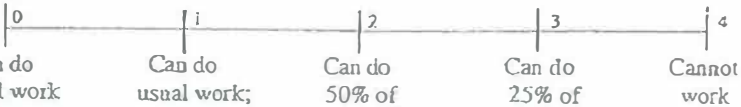


3. Personal Care (washing, dressing, etc.)

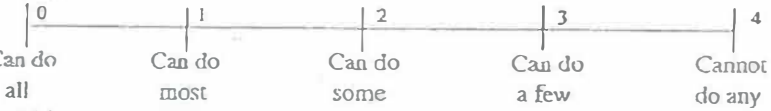


4. Travel (driving, etc.)

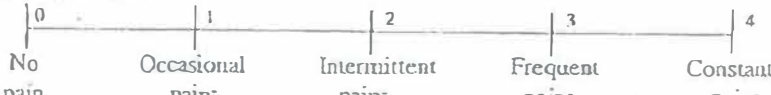
5. Work



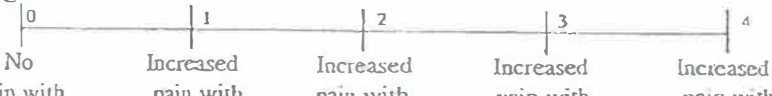
6. Recreation



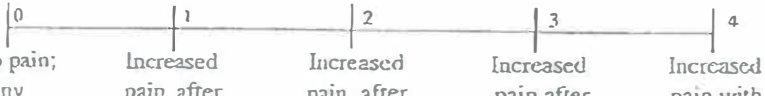
7. Frequency of pain



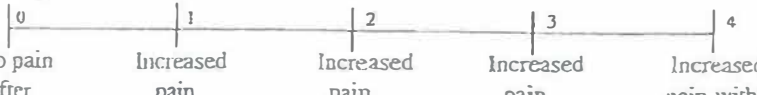
8. Lifting



9. Walking



10. Standing



Name _____ ID# _____ Plan ID _____ Total Score _____

PRINTED

Revised 10/07

_____ Signature

_____ Date