ZUCKERMAN FAMILY WELLNESS CENTER Date: ___/___/___

Full Name ____________________________________ Nickname _______________________

Address _________________________________ City ______________ State ___ Zip __________

SSN ____- _____- _____ Marital Status ___________ Sex ____ Age _____ DOB ____________

Phone _________________ Work Phone _______________ Cell Phone ______________________

Occupation _________________ Email ____________________ Employer __________________

Spouse's Name ________________ Emergency Contact Name & Phone ____________________

How did you hear about our office? ___________ Who is your primary care doctor? ___________

Who Is Responsible For Your Bill: PPO ___ HMO ___ AUTO ___ CASH ___ Medicare ___

What brought you into our office today (chief complaint):

____

____

Is your condition due to: □ An Auto Accident □ A Personal Injury □ A Work Injury □ Other

HEALTH CARE AUTHORIZATIONS: *(Please Cross Out Any Permission You Would Like To Revoke)*

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

B. I give permission to Zuckerman Family Wellness Center to use my address, phone number, email and clinical records to contact me with birthday cards, holiday related cards, information about treatment alternatives, office seminar dates, patient appreciation dates or other health related information such as newsletters.

C. I give permission to Zuckerman Family Wellness Center to use my name and clinical records to display my photos or x-rays and use my testimonial and experience in an effort to increase the public's awareness of chiropractic.

D. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with a doctor at any time in private, the doctor will provide a room for these conversations.

E. I understand that my travel card (Daily Visit Chart) contains protected health information and that I should keep it in my possession and upside down to prevent this information from being seen by another patient.

F. I authorize Zuckerman Family Wellness Center to take any x-rays the doctor determines will be beneficial to my case during the course of my care. I also recognize that if I am a female it is my responsibility to notify the doctor if I am pregnant or it is possible that I am pregnant.

Date of Last Menstrual Period______________.

G. I am giving Zuckerman Family Wellness Center permission to use and disclose my protected health information in accordance with the directives listed above.

H. I am giving Zuckerman Family Wellness Center permission to contact other health care providers, including my primary care physician, on my behalf to discuss treatment recommendations and co-management of my health care problems. Further, I am giving permission for Zuckerman Family Wellness Center to provide written information regarding my consultation and exam results to my primary care physician and any other related doctor.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand I have the following rights and privileges: The right to view the notice prior to signing this consent, the right to object to the use of my health information for directory purposes, and the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

RIGHT TO REVOKE AUTHORIZATION:

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to Zuckerman Family Wellness Center. This AUTHORIZATION is requested by Zuckerman Family Wellness Center for its own use/disclosure of PHI.

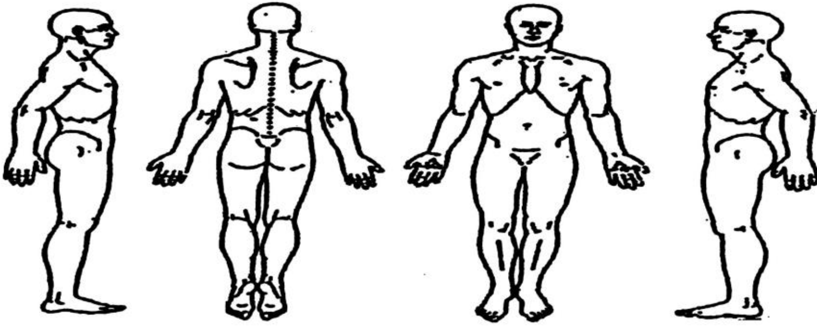
Patient Signature: ____ **Date:** ____________________________

Parent or Guardian: _______________________________________ **Date:** ____________________________

PATIENT INTAKE FORM

Patient Name: ______________________________ Date: _______________

Indicate on the drawings below all the areas where you have pain/symptoms:



First Complaint: ____

How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_________________

How are your symptoms changing with time? □ Getting Worse □ Staying the same □ Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your problem?

Indicate Pain Level (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Shoot Me Pain)

How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely □ N/A

How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

Who else have you seen for your problem?

□ Chiropractor □ Massage Therapist □ Primary Care Physician □ Neurologist
□ Orthopedist □ ER physician □ Physical Therapist □ Other:____________

Provider Name / Date of visit: ____

How long have you had this problem? ____

How do you think your problem began? □ Cause Not Known □ Auto Accident □ Work Injury □ Slip / Fall
□ Sports Injury □ Other _______

What aggravates your problem?

□ Nothing □ Sneezing □ Bending □ Coughing □ Lifting □ Walking □ Reaching □ Sitting □ Straining at Stool
□ Standing □ Pulling □ Turning □ Other – Describe: ____

What makes your problem better?

□ Nothing □ Rest □ Sitting □ Stretching □ Exercise □ Standing □ Heat □ Ice □ Medications □ Massage
□ Adjustments □ Sleeping □ Other – Describe:____

Do you consider this problem to be severe? □ Yes □ Yes, at times □ No

What concerns you the most about your problems; what does it prevent you from doing?

____

Second Complaint: ____

How often do you experience your symptoms?
□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

How would you describe the type of pain?
□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_________________

How are your symptoms changing with time? □ Getting Worse □ Staying the same □ Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your problem?

Indicate Pain Level (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Shoot Me Pain)

How much has the problem interfered with your work?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely □ N/A

How much has the problem interfered with your social activities?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

Who else have you seen for your problem?
□ Chiropractor □ Massage Therapist □ Primary Care Physician □ Neurologist
□ Orthopedist □ ER physician □ Physical Therapist □ Other:____________

Provider Name / Date of visit: ____

How long have you had this problem? ____
How do you think your problem began? □ Cause Not Known □ Auto Accident □ Work Injury □ Slip / Fall □ Sports Injury □ Other ________________________________

What aggravates your problem?
□ Nothing □ Sneezing □ Bending □ Coughing □ Lifting □ Walking □ Reaching □ Sitting □ Straining at Stool
□ Standing □ Pulling □ Turning □ Other Describe:____

What makes your problem better?
□ Nothing □ Rest □ Sitting □ Stretching □ Exercise □ Standing □ Heat □ Ice □ Medications
□ Massage □ Adjustments □ Sleeping □ Other – Describe: ____

Do you consider this problem to be severe? □ Yes □ Yes, at times □ No

What concerns you the most about your problems; what does it prevent you from doing?

____

What is your: Height___________ **Weight** _____________ **Date of Birth** ________

Occupation ____

How would you rate your overall Health? □ Excellent □ Very Good □ Good □ Fair □ Poor

What type of exercise do you do? □ Strenuous □ Moderate □ Light □ None

Indicate if you have any immediate family members with any of the following:

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

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 Dependance
□	□ 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	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		

□ □ Other:____

List all prescription medications you are currently taking: (feel free to include separate list if needed)

____

List all of the supplements you are currently taking:

____

List all surgical procedures you have had:

____

What activities do you do at work? □ Do Not Work / Retired

□ Sit:	□ Most of the day	□ Half the day	□ A little of the day
□ Stand:	□ Most of the day	□ Half the day	□ A little of the day
□ Computer work:	□ Most of the day	□ Half the day	□ A little of the day
□ On the phone:	□ Most of the day	□ Half of the day	□ A little of the day

What activities do you do outside of work?
____

Have you ever been hospitalized? □ No □ Yes

if yes, when and why ____

Have you had significant past trauma? □ No □ Yes If yes, please list all previous traumas

____

Anything else pertinent to your visit today?____

Patient Signature____ **Date:**____________________

Zuckerman Family Wellness Center
Dr. Adam D. Zuckerman, P.A.
8280 Jog Road
Boynton Beach, FL 33472
Phone: (561) 752-4646 Fax: (561) 737-7664

Authorization For Release of Protected Health Information

Patient Name: ________________________________ Birth Date: ______________

Social Security #: _____________________________

I hereby authorize the release of medical records to Zuckerman Family Wellness Center. I understand that I may revoke this authorization at any time. My revocation must be in writing, on a form that will be provided to me upon request. I am aware that my revocation will not be effective to the extent that Zuckerman Family Wellness Center has acted in reliance on this authorization. I understand that if my protected health information is disclosed to someone who is not required to comply with the Federal Privacy regulations, then such information may be re-disclosed and no longer protected by the Federal Privacy regulations. I release Zuckerman Family Wellness Center and its workforce members from all liability arising from the disclosure of my health information pursuant to this agreement. I have the above and authorize the disclosure of protected health information as stated.

______________________________________ ____________________
Signature of Patient/Patient Representative Date

______________________________________ ____________________
Print Name of Patient/Patient Representative Relationship to Patient