



Date: \_\_\_\_\_

Medical History

Primary Care Provider

Name: \_\_\_\_\_ Phone#: \_\_\_\_\_ Fax: \_\_\_\_\_

Have you been to a Chiropractor before?  No  Yes, Name: \_\_\_\_\_

Is there any chance you may be pregnant?  No  Yes, Expected Due Date: \_\_\_\_\_

When was your last: Physical Exam: \_\_\_\_\_ Xray: \_\_\_\_\_  
Spinal Exam: \_\_\_\_\_ MRI/CT scan/Bone Scan: \_\_\_\_\_

What medications are you taking?  Pain Killers (including aspirin)  Muscle Relaxers  Blood Thinners  
 Other: \_\_\_\_\_

How often do you exercise:  Never  Sometimes  Weekly  Daily

What is your work activity like:  Sitting all day  Standing all day  Light Labor  Heavy labor

Do you:  Smoke? Packs/day \_\_\_\_\_  Drink Alcohol? Drinks/week \_\_\_\_\_  
 Drink coffee? Cups/day \_\_\_\_\_  Have high stress levels? Reason \_\_\_\_\_

Have you had any recent injuries or surgeries? When were they and what did they involve? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is the reason for your visit? Major complaints or concerns? How long have you had the symptoms?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are your symptoms:  Getting worse?  Getting better?  Fluctuating?

What treatments have you received for your condition?  Medication  Surgery  Physical Therapy  
 Chiropractic  None  Other: \_\_\_\_\_

Have you seen any other doctors for this condition?  No  Yes, please fill out their information below:

Physician Name: \_\_\_\_\_ Care type: \_\_\_\_\_

Address: \_\_\_\_\_

Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_

On a scale of 1 – 10, how bad would you rate your pain today? \_\_\_\_\_

How often do you have this pain:  Constant  Fluctuating  Random Flare Ups  Induced

Does it interfere with:  Work?  Sleep?  Daily Routines?  Recreation?

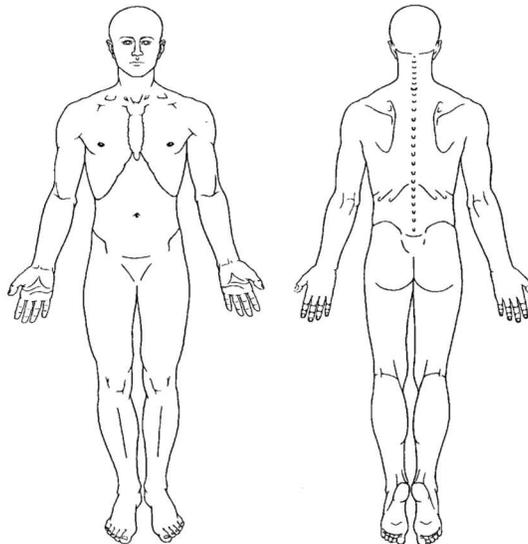
Which of these are painful to perform:  Sitting  Standing  Walking  Bending  Lying down

Check off “Yes” or “No” if you have had any of the following:

- |                      |  |                        |  |                       |  |
|----------------------|--|------------------------|--|-----------------------|--|
| Weight loss or gain  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen glands         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Calf pain w/ walking  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fever or Chills      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cough                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Leg Cramping          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rashes               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of breath    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dizziness             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Itching              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Wheezing               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hair/Nail changes    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chest pain/discomfort  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weakness              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Decreased hearing    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heartburn              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Numbness              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Earache              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diarrhea               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heat/cold Intolerance | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ringing in ears      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Constipation           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervousness/anxiety   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pain in eyes         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Burning/pain urination | <input type="checkbox"/> Yes <input type="checkbox"/> No | Depression            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blurry/double vision | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood in Urine         | <input type="checkbox"/> Yes <input type="checkbox"/> No |                       |  |
| Sinus pain           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Incontinence           | <input type="checkbox"/> Yes <input type="checkbox"/> No |                       |  |

Check off the type of pain you feel:  Sharp  Dull  Throbbing  Aching  Shooting  
 Burning  Numbness  Tingling  Stiffness  Other: \_\_\_\_\_

**Place an X to mark the areas of discomfort**



\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

## Informed Consent to Chiropractic Treatment

**The Nature of Chiropractic treatment:** A chiropractic adjustment is the specific application of forces to facilitate the correction of vertebral subluxation. Chiropractic adjustments are a “hands on” approach to patient wellness. Subluxation is a misalignment of one or more of the vertebrae in the spinal column. This subluxation can cause alteration of the functioning of the nerves, leading to pain and dysfunction. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked”, and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, traction, passive and active exercise may also be used.

**Permission for Physical Contact:** I understand that, during various chiropractic examination procedures and treatment methods, the Doctor of Chiropractic or other clinical staff may have to examine and physically contact portions of my body. I understand that any contact of an intimate or sexual nature is illegal, unethical, never a part of chiropractic professional examination or treatment and is prohibited. Nevertheless, I also realize that some chiropractic procedures may require that the doctor or clinician contact me in some physically sensitive areas, such as underarm areas, over buttock/hip areas, and/or upper thigh muscles. However, before any sensitive contact or procedure occurs, the doctor or other clinical staff member will explain to me what is to be done, how it will be performed, and why it will be performed. I may refuse that test or procedure, or alternatively I may request that another member of the staff be present.

**Possible Risks:** As with any health care procedure, complications are possible following a chiropractic adjustment. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, and/or injury to vertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications if you are allergic to latex, rubber, or cloth used in the towels. Please inform the doctor if you have any such allergies.

**Probability of risks occurring:** The risks of complications due to chiropractic treatment, cerebrovascular injury or stroke, or adverse reaction due to ancillary procedures is rare. Please inform the doctor if you have any pre-existing vascular conditions.

**Other treatment options which could be considered may include the following:** Over the counter analgesics, medical care, hospitalization, and/or surgery.

**Risks of remaining untreated:** Delay of treatments allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition, making future rehabilitation more difficult.

**I have read the following risks of care and explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.**

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Printed Name

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Signature

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Date



Consent To Request/Release Medical Records (HIPAA)

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Under the Health Insurance Portability and Accountability Act (HIPAA), enforced by the US Department of Health and Human Services office of Civil Rights, we are not permitted to request or release any medical records or patient information without having exclusive permission from the patient.

This waiver, in accordance with your wishes below, authorizes **Link Medical Services PLLC**, parent company of **Fasulo Chiropractic**, to request/release your medical information as noted:

- 1. We may leave a voicemail recording regarding personal health information, appointment confirmations, treatments, disorder related information, lab or other results on: (select all that apply)
  - Home Phone       Cell Phone       Work Phone
- 2. We may send an email, even is the email is not encrypted, regarding personal health information, appointment confirmations, treatments, disorder related information, lab or other results:
  - Yes       No       Other: \_\_\_\_\_
- 3. Link Medical Services PLLC may request my medical history, laboratory reports, x-rays, and any other material regarding medical consultations and treatment I received. The request may be made to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone#: \_\_\_\_\_ Fax: \_\_\_\_\_

If there are any questions concerning this request, you may contact our office at (631)289-3939. You may fax the records to (631)289-3934.

I have received and reviewed this notice, which describes how my medical information may be used and disclosed and explains how I can get access to this information. I had an opportunity to raise questions regarding this policy and all my questions have been answered.

The authorizations made above will remain in effect until such time as I notify Fasulo Chiropractic in writing of the requested changes.

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**Printed Name** **Signature** **Date**



## Disclosure of Physician Ownership in Healthcare Entities

Dear Patient,

New York State requires that you be notified of any potential or existing financial relationships between our physicians and any other entities or individuals that are providing you with care. Mariwalla Neurosurgery has no financial relationships with any hospitals, emergency room physicians, anesthesiologists, pain management physicians, or other healthcare providers directly involved in your surgery care. As part of the safety and standard to be met for this region and for its patients, Mariwalla Neurosurgery has recruited top professionals in the fields of neurophysiology, neurology, and intraoperative neuromonitoring. Mariwalla Neurosurgery has spent considerable time and effort to ensure that you are as safe as possible during your surgery, and since neuromonitoring is not a service provided by the hospital, he has invested a financial interest in NeuroLink Monitoring, LLC. which is one of the many companies that you may elect to perform your intraoperative neuromonitoring. You have the right to choose the provider for your healthcare services, and this has absolutely no bearing on how you will be treated by Dr. Mariwalla or any of his associates. By signing this form, you acknowledge that you have been provided this information and have been explained all financial disclosure.

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**Printed Name**

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**Signature**

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**Date**