Patient History

Date of Birth________________________ Age______ SS#____________________

Last__________________________________ First_______________________________ Middle Initial________

Address____ City____________________ ST______ Zip________

Phone (H)______________________ (W)___________________ (C)____________________

Email_______________________________________

Occupation___________________________ Employer____

Spouse's Name___________________________ Spouse DOB____

Spouse SS#____________________

Have you been to another Dr. with this problem? YES___ NO___ Where? __________________________
Who may we thank for referring you to the office? ______________________________________

WHAT BRINGS YOU TO OUR OFFICE? Please provide as much detail as possible

PRIMARY COMPLAINT: ____

Date when symptoms appeared__________________ Did it begin: Gradual___ Sudden___ Progressed over time__________________

What makes the symptoms increase? ____________________ What relieves the symptoms? ________________________________

Type of pain: Sharp___ Dull___ Ach___ Burn___ Throb____ Does the pain radiate into your: Arm___ Leg___ Does not radiate___________

Do you have Numbness or Tingling? YES_______________________________________ NO_____________________________

How often do experience these symptoms? 100%___ 75%___ 50%___ 25%___ 10%___

Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms 10 being extreme) ___________________________

Please list all previous treatments for this condition (provide doctors name if possible) ____

Do you have any family members that suffer from the same complaint? If so, who? ____

SECONDARY COMPLAINT: ____

Date when symptoms appeared__________________ Did it begin: Gradual___ Sudden___ Progressed over time__________________

What makes the symptoms increase? ____________________ What relieves the symptoms? ________________________________

Type of pain: Sharp___ Dull___ Ach___ Burn___ Throb____ Does the pain radiate into your: Arm___ Leg___ Does not radiate___________

Do you have Numbness or Tingling? YES_______ NO_________

How often do experience these symptoms? 100%___ 75%___ 50%___ 25%___ 10%___

Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms 10 being extreme) ___________________________

Please list all previous treatments for this condition (provide doctors name if possible) ____

____

Do you smoke? YES ___ NO___ If yes, how many packs per week? _____________

Have you ever smoked in the past? YES___ NO___ If yes, when did you quit? _____________

Do you take birth control? YES ____ NO _____ Have you ever taken birth control in the past? YES ____ NO ____

Do you consume alcohol? YES ____ NO _____ If yes, how many drinks per day? __________

Do you consume caffeine? YES ____ NO _____ If yes, how many drinks per day? ____

Do you exercise? YES ____ NO ____ If yes, how many times per week and what type? ______________________________________

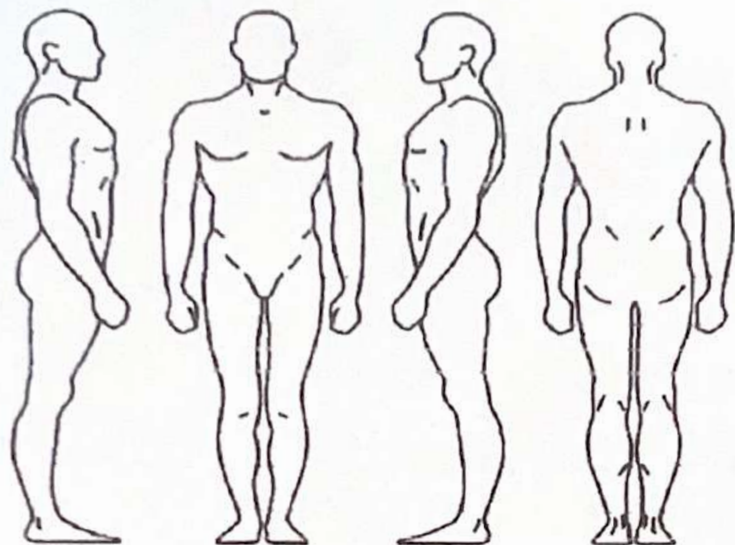
Do you have a high stress level? YES ______ NO______ If yes, what reasons? ____

Please list any medications or vitamins you are currently taking: ____

PATIENT SIGNATURE: ____ DATE: _______________________

Please mark off the areas of your complaint on the diagram below with the following Indicators

PPP= Pain, NNN= Numbness, TTT= Tingling, BBB= Burning, CCC+ Cramping, XXX= Other



Please list all surgeries, injuries, accidents, falls, etc. ____________________

____

Please check if you have had any of the following:

☐ AIDS/HIV	☐ Alcoholism	☐ Anemia	☐ Allergy Shots	☐ Anorexia
☐ Arthritis	☐ Asthma	☐ Bleeding Disorders	☐ Breast Lump	☐ Bronchitis
☐ Bulimia	☐ Cancer	☐ Cataracts	☐ Chemical Dependency	☐ Chicken Pox
☐ Diabetes	☐ Disc Degeneration	☐ Emphysema	☐ Epilepsy	☐ Glaucoma
☐ Goiter	☐ Gonorrhea	☐ Gout	☐ Hart Attack	☐ Heart Disease
☐ Hepatitis	☐ Hernia	☐ Herpes	☐ HBP	☐ High Cholesterol
☐ Kidney Disease	☐ Liver Disease	☐ Measles	☐ Migraines	☐ Miscarriage
☐ Mononucleosis	☐ MS	☐ Mumps	☐ Osteoporosis	☐ Pacemaker
☐ Parkinson's	☐ Pinched Nerve	☐ Pneumonia	☐ Rheumatic Fever	☐ Rheumatoid Arthritis
☐ Scarlet Fever	☐ Stroke	☐ Suicide Attempt	☐ Thyroid Disease	☐ Tonsillitis
☐ Tuberculosis	☐ Typhoid Fever	☐ Ulcers	☐ Venereal Disease	☐ Vaginal Infections
☐ Tumors/Growths	☐ Whooping Cough	Other:		

PATIENT SIGNATURE: ______________________________ **DATE:** __________

Rockaway Family Chiropractic

Informed Consent to Care

You are the decision maker of your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect of your health if you chose not to receive care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed, but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation of a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important to understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including, but not limited to, hot packs and ice, fractures (broken bones), disk injuries, stroke, discolorations, strains and sprains. With respect to strokes, there is a rare but serious condition known as arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombosis (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with a stroke is exceedingly rare and is estimated to be related to one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these treatment options already. These options may include, but are not limited to: self-administered care, over the counter relievers, Physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery, Lastly, you have the right to a second opinion and to secure other options about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had the opportunity to ask questions about this content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for future condition(s) for which I seek chiropractic care and for my children from the providers in this office

Patient Name:________________________________ Signature:_______________________________ Date:___________

Parent or Guardian:___________________________ Signature:_______________________________ Date:___________

Names of Children: 1.__________________________ 2.________________________

3.__________________________ 4.__________________________

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the healthcare provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the healthcare provider and/or other licensed healthcare providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the healthcare provider, including those working at the healthcare provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the healthcare provider, and/or the healthcare provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) and provide National Arbitration and Mediation ("NAM") with the party arbitrator's contact information within thirty days of the date Respondent files its initial responsive pleading. A third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties from a list of arbitrators supplied by National Arbitration and Mediation ("NAM") within thirty days thereafter. The list supplied by NAM shall be a list of between 5 and 10 arbitrators, depending upon availability. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's equal share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that, where not in conflict with this agreement, the Healthcare Malpractice Dispute Resolution Rules and Procedures of NAM shall govern any arbitration conducted pursuant to this Arbitration Agreement. A copy of NAM rules are available on its website at https://www.namadr.com or by calling 1-800-358-2550 to request a copy of the rules.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the healthcare provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _______. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient Name (print): ________________________ Signature: ________________________________ Date: _______________

Parent or Guardian (print): ____________________ Signature: ________________________________ Date: _______________

Office Name: ______________________________ Signature: ________________________________ Date: _______________

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

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Rockaway Family Chiropractic

129-10 Newport Avenue
Belle Harbor, NY 11694
Dr.Vincent Esposito (718) 634-4800

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, ____, hereby authorize Dr.Vincent Esposito and/or
(Print Name)
his current and future staff to share my medical documents and X-Rays, and/or the medical documents and X-Rays of my children under the age of 18, if necessary, with other medical health professionals. This includes, but is not limited to; other chiropractors, radiologists, hospitals, clinics, medical doctors, etc.

I understand the purpose of this authorization is to help give me and/or my children the best possible health care by allowing Dr. Xkpegpv"Gurqukvq, if needed, to consult with other medical professionals.

I do not authorize further release to any third party. I understand that once information is released pursuant of this authorization, the hospital, clinics, their employees and my physician(s) cannot prevent the redisclosure of that information. I hereby release each of them from any and all liability arising directly, or indirectly, from the disclosure authorized by this consent and any redisclosure of any information.

I understand that I may revoke this consent at any time.

____ ______________
Patient/Legal Guardian Signature *Date*

____ ______________
Witness Signature *Date*