Thank you from Dr. Lawrence J. Suchoff

We are once again converting our computer program and need to update your file.

Thank you for helping us by sharing the information requested.

Name: _____

Address: _____

City _____ **State** _____ **Zip Code** _____

Phone: Home _____ **Cell** _____ **Work** _____

Email _____

Date of Birth _____

Are you: Married _____ **Single** _____ **Divorced** _____ **Widowed** _____

Social Security # _____

Please tell us who referred you to our office: _____

Are you: Working _____ **Retired** _____ **Full Time Student** _____ **Other** ____

Occupation: _____

Primary Insurance Carrier: _____

Patient ID# _____ **Group #** _____

Relationship to insured: Self ___ **Spouse** ____ **Parent** ___ **Other** _____

If NOT SELF, Name of Policy Holder_____

Policy Holder Date of Birth _____ **Policy Holder SS#** _____

Copay Amt $ _____ **Deductible: Yes** ____ **No** ____ **Amount $**_____

Secondary Insurance Carrier: _____

Patient ID# _____ **Group #** _____

Who is the insured? Self _____ **Spouse** _____ **Parent** _____ **Other** _____

If NOT self, name of Policy Holder_____

Policy Holder Date of Birth _____

Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

NAME _____ DATE _____ HOME PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ WORK PHONE _____

DATE OF BIRTH ____/____/____ AGE _____ M ☐ F ☐ MARITAL STATUS _____ NO. CHILDREN _____ FAX # _____

OCCUPATION _____ SS# _____ SPOUSE _____ E-MAIL _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____ REFERRED BY _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O - OCCASIONAL
F - FREQUENT
C - CONSTANT

O F C

GENERAL
- ☐ ☐ ☐ Allergy
- ☐ ☐ ☐ Chills
- ☐ ☐ ☐ Convulsions
- ☐ ☐ ☐ Dizziness
- ☐ ☐ ☐ Fainting
- ☐ ☐ ☐ Fatigue
- ☐ ☐ ☐ Fever
- ☐ ☐ ☐ Headache
- ☐ ☐ ☐ Loss of sleep
- ☐ ☐ ☐ Loss of weight
- ☐ ☐ ☐ Nervousness/depression
- ☐ ☐ ☐ Neuralgia
- ☐ ☐ ☐ Numbness
- ☐ ☐ ☐ Sweats
- ☐ ☐ ☐ Tremors

MUSCLE & JOINT
- ☐ ☐ ☐ Arthritis
- ☐ ☐ ☐ Bursitis
- ☐ ☐ ☐ Foot trouble
- ☐ ☐ ☐ Hernia
- ☐ ☐ ☐ Low back pain
- ☐ ☐ ☐ Lumbago
- ☐ ☐ ☐ Neck pain or stiffness
- ☐ ☐ ☐ Pain between shoulders

Pain or numbness in:
- ☐ ☐ ☐ Shoulders
- ☐ ☐ ☐ Arms
- ☐ ☐ ☐ Elbows
- ☐ ☐ ☐ Hands
- ☐ ☐ ☐ Hips
- ☐ ☐ ☐ Legs
- ☐ ☐ ☐ Knees
- ☐ ☐ ☐ Feet
- ☐ ☐ ☐ Painful tail bone
- ☐ ☐ ☐ Poor posture
- ☐ ☐ ☐ Sciatica
- ☐ ☐ ☐ Spinal curvature
- ☐ ☐ ☐ Swollen joints

O F C

GASTRO-INTESTINAL
- ☐ ☐ ☐ Belching or gas
- ☐ ☐ ☐ Colitis
- ☐ ☐ ☐ Colon trouble
- ☐ ☐ ☐ Constipation
- ☐ ☐ ☐ Diarrhea
- ☐ ☐ ☐ Difficult digestion
- ☐ ☐ ☐ Distension of abdomen
- ☐ ☐ ☐ Excessive hunger
- ☐ ☐ ☐ Gall bladder trouble
- ☐ ☐ ☐ Hemorrhoids
- ☐ ☐ ☐ Intestinal worms
- ☐ ☐ ☐ Jaundice
- ☐ ☐ ☐ Liver trouble
- ☐ ☐ ☐ Nausea
- ☐ ☐ ☐ Pain over stomach
- ☐ ☐ ☐ Poor appetite
- ☐ ☐ ☐ Vomiting
- ☐ ☐ ☐ Vomiting of blood

EYES, EARS, NOSE & THROAT
- ☐ ☐ ☐ Asthma
- ☐ ☐ ☐ Colds
- ☐ ☐ ☐ Crossed eyes
- ☐ ☐ ☐ Deafness
- ☐ ☐ ☐ Dental decay
- ☐ ☐ ☐ Earache
- ☐ ☐ ☐ Ear discharge
- ☐ ☐ ☐ Ear noises
- ☐ ☐ ☐ Enlarged glands
- ☐ ☐ ☐ Enlarged thyroid
- ☐ ☐ ☐ Eye pain
- ☐ ☐ ☐ Failing vision
- ☐ ☐ ☐ Far sightedness
- ☐ ☐ ☐ Gum trouble
- ☐ ☐ ☐ Hay fever
- ☐ ☐ ☐ Hoarseness
- ☐ ☐ ☐ Nasal obstruction
- ☐ ☐ ☐ Near sightedness
- ☐ ☐ ☐ Nosebleeds
- ☐ ☐ ☐ Sinus infection
- ☐ ☐ ☐ Sore throat
- ☐ ☐ ☐ Tonsillitis

O F C

CARDIO-VASCULAR
- ☐ ☐ ☐ Hardening of arteries
- ☐ ☐ ☐ High blood pressure
- ☐ ☐ ☐ Low blood pressure
- ☐ ☐ ☐ Pain over heart
- ☐ ☐ ☐ Poor circulation
- ☐ ☐ ☐ Rapid heart beat
- ☐ ☐ ☐ Slow heart beat
- ☐ ☐ ☐ Swelling of ankles

RESPIRATORY
- ☐ ☐ ☐ Chest pain
- ☐ ☐ ☐ Chronic cough
- ☐ ☐ ☐ Difficult breathing
- ☐ ☐ ☐ Spitting up blood
- ☐ ☐ ☐ Spitting up phlegm
- ☐ ☐ ☐ Wheezing

SKIN
- ☐ ☐ ☐ Boils
- ☐ ☐ ☐ Bruise easily
- ☐ ☐ ☐ Dryness
- ☐ ☐ ☐ Hives or allergy
- ☐ ☐ ☐ Itching
- ☐ ☐ ☐ Skin eruptions (rash)
- ☐ ☐ ☐ Varicose veins

GENITO-URINARY
- ☐ ☐ ☐ Bed-wetting
- ☐ ☐ ☐ Blood in urine
- ☐ ☐ ☐ Frequent urination
- ☐ ☐ ☐ Inability to control kidneys
- ☐ ☐ ☐ Kidney infection or stones
- ☐ ☐ ☐ Painful urination
- ☐ ☐ ☐ Prostate trouble
- ☐ ☐ ☐ Pus in urine

FOR WOMEN ONLY
- ☐ ☐ ☐ Congested breasts
- ☐ ☐ ☐ Cramps or backache
- ☐ ☐ ☐ Excessive menstrual flow
- ☐ ☐ ☐ Hot flashes
- ☐ ☐ ☐ Irregular cycle
- ☐ ☐ ☐ Menopausal symptoms
- ☐ ☐ ☐ Painful menstruation
- ☐ ☐ ☐ Vaginal discharge
- ☐ Yes ☐ No Are you pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Cancer
- ☐ Chorea
- ☐ Cold sores
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Lumbago
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Whooping cough

Have you ever had previous chiropractic care? _____ If yes, date of last care _____

Do you have Health and Accident Insurance? _____ If yes, with what company? _____

Is this an Industrial Accident Case? ☐ Yes ☐ No

What is your major complaint? _____

_____

Other complaints: _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

Is this condition interfering with your: ❑ Work ❑ Sleep ❑ Daily routine ❑ Other _____

How long has it been since you really felt good? _____

List previous diagnoses and treatments you have received for present condition: _____

What do you believe is wrong with you? _____

List surgical operations and years: _____

_____

Drugs you now take: ❑ Nerve pills ❑ Pain killers ❑ Muscle relaxers ❑ "Pep" pills ❑ Tranquilizers ❑ Birth control pills
Others _____

Dental visits: ❑ Every six months ❑ Yearly ❑ Toothache or emergency only ❑ Complete dentures

Age of mattress: _____ ❑ Comfortable ❑ Uncomfortable Do you use a bed board? _____

Are you wearing: ❑ Heel lifts ❑ Sole lifts ❑ Inner soles ❑ Arch supports

Have you been in an auto accident: ❑ Past year ❑ Past five years ❑ More than five years ❑ Never
Describe _____

Have you ever had any mental or emotional disorders? ❑ Yes ❑ No When? _____
Have others in your family had such disorders? ❑ Yes ❑ No When? _____

FAMILY HEALTH INFORMATION (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health picture.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

HAVE YOU EVER:	Yes	No	DESCRIBE BRIEFLY
Been knocked unconscious?	❑	❑	
Used a cane, crutch, or other support?	❑	❑	
Been treated for a spine or nerve disorder?	❑	❑	
Had a fractured bone?	❑	❑	
Been hospitalized for other than surgery?	❑	❑	

DO YOU:	Yes	No	DESCRIBE BRIEFLY
Now take vitamins or minerals?	❑	❑	
Think you may need vitamins or minerals?	❑	❑	
Have an allergy to any drug?	❑	❑	

DATE OF LAST:	Less than 6 months	6-18 months	Over 18 months	Never
Spinal examination	❑	❑	❑	❑
Physical examination	❑	❑	❑	❑
Blood test	❑	❑	❑	❑
Chest x-ray	❑	❑	❑	❑
Spinal x-ray	❑	❑	❑	❑

HABITS	Heavy	Moderate	Light	None
Alcohol	❑	❑	❑	❑
Coffee	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑
Drugs	❑	❑	❑	❑
Exercise	❑	❑	❑	❑
Sleep	❑	❑	❑	❑
Appetite	❑	❑	❑	❑

LIST BELOW ALL CONDITIONS FOR WHICH YOU HAVE BEEN TREATED IN THE PAST 10 YEARS

_____

_____

_____

_____

_____

IN CASE OF EMERGENCY (Name of relative or close friend not living in your home):

Name _____

Address _____ Phone _____

CASE HISTORY UPDATE

In order for us to best serve you, and so that we may bring your original case history up to date, please provide us with the following information. **PLEASE PRINT**

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone (Home): _____ (Office): _____

1. Is your visit to this clinic in reference to an accident? ❒ Yes ❒ No

   If Yes, was it: ❒ Work Comp ❒ Automobile ❒ Personal Injury ❒ Other _____

2. List present complaints (describe fully): _____

   _____

   _____

3. Duration of present condition: _____ What do you believe caused this condition? _____

   _____

4. Describe any falls, surgery, and/or accidents since last visit: _____

   _____

   _____

5. Date of last physical: _____ Date of last adjustment: _____

6. Since your last office visit here, have you consulted another Doctor? ❒ Yes ❒ No

   If so, please give the Doctor's name: _____

   and condition for which you were treated: _____

7. What type of treatment did you receive? _____

8. What medications or drugs are you taking? _____

9. Other information the Doctor should know regarding this condition: _____

INSURANCE DATA - *Clinic policy requires payment arrangements be made on first visit.*

Name of persons responsible for payment: _____ Telephone: _____

Do you have insurance? ❒ No ❒ Yes Company _____

Please list all sources of insurance:

Employee I.D. # _____

❒ Group Insurance _____ Policy # _____
Name

Group # _____

❒ Spouse's Insurance _____
Name

❒ Worker's Compensation _____
Name

❒ Other _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's Signature: _____ Date _____

Guardian or Spouse's
Signature Authorizing Care _____ Date _____

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: ___/___/_____ **Gender: ( ) Male ( ) Female**

Your Employer:_____ Occupation: _____

Employers Address: _____

Preferred Language: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

***If more than 3 medications, please continue list on back of page**

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

For office use only

Height: _____ Weight:_____ Temp: _____

Blood Pressure:_____/_____ Heart Rate: _____

LAWRENCE J. SUCHOFF, D.C.

INFORMED CONSENT TO CHIROPRACTIC CARE

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to **move your joints. 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 or hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral 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.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been **described as "rare", about as often as complications are seen from the taking of a single aspirin tablet.** The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction **due to ancillary procedures is also considered "rare".**

Other treatment options which could be considered may include the following:

***Over**-the-counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.

***Medical care, typically anti**-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include gastrointestinal bleeding, kidney and liver disease as well as other undesirable side effects and patient dependence in a significant number of cases.

***Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable** disease in a significant number of cases.

***Surgery in conjunction with medical care adds the risks of infection and adverse reaction to anesthesia** as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment 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 and make future rehabilitation more difficult

Unusual risks: I have had the following unusual risks of my case explained to me. I have read the 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.

PATIENT SIGNATURE_____DATE:_____.

I have reviewed the risks of my treatment, alternative forms of treatment a well as remaining untreated with the patient. I have also afforded the patient the opportunity to ask any questions and have answered them to their satisfaction.

DOCTORS SIGNATURE_____DATE:_____.

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AUTHORIZATION, ASSIGNMENT & RELEASE FORM

AUTHORIZATION AND ASSIGNMENT

consideration of your undertaking to care for me, I agree to the following:

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.

I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed, directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due, I personally owe and agree to pay to you.

In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of _____.

I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.

This Authorization (or Assignment will be in continual effect until revoked by both parties.

_____ _____
Date Patient/Insured Signature

RECORDS RELEASE

_____, I hereby authorize you to release to _____ any information luding the diagnosis and records of treatment or examination rendered to me for all care during the period from _____ _____.

_____ _____
Date Patient/Insured Signature

_____ _____
Date Staff Signature

RELEASE FROM CARE

_____ hereby understand that Dr. _____ is releasing me from care, for my ident dated _____, and that I have reached ☐ a pre-accident status or ☐ maximum medical improvement. I her understand that all expenses incurred from this accident are my responsibility or the insurance company's and that all enses incurred after the date below will be my personal responsibility. I will make financial arrangements for payment ely.

_____ _____ _____
ent Signature Date Staff Signature