Tel: 212-742-8000
Fax: 212-742-1557
Monday – Friday 10:00 am – 7: 00pm

New Patient Form

Please fill out completely, print, sign and date the form and bring with you to your first appointment

Patient Name: Last ______________ First ______________ M ____SS# ______________

Address ______________City ______________ State_____Zip________

Email Address: ______________ Home #______________ Cell # ______________

Date of Birth:______________ Referred By ______________ Status: S ☐ M ☐ D ☐ W ☐ Gender M ☐ F ☐

Occupation ______________ Employer ______________Work # ______________

Employer's Address______________City ______________ State_____Zip________

In Case of an Emergency:

Who should we contact? ______________Relationship: ______________

Home Phone #: ______________Work Phone #: ______________ ext.__________

Reason for Visit:

The reason for this visit is a result of: ☐ Work ☐ Sports ☐ Auto ☐ Chronic ☐ Trauma ☐ Unknown

When did the condition begin: ______________Is this condition getting worse? Yes ☐ ☐ No ☐ Unchanged

Describe what happened: ______________

Describe your main complaint & its location:______________

Grade your Primary Complaints (how you feel today):

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain Unbearable Pain

How often are your symptoms present?

☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Describe the secondary complaint & its location:______________

Grade your Secondary Complaints (how you feel today):

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain Unbearable Pain

How often are your symptoms present?

☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Have you been treated by another provider for this condition? ☐ Yes ☐ No ______________

Have you had any spinal X-Rays, MRI or CT Scans for your area(s) of complaint? ☐ Yes ☐ No list areas taken:

____

Please bring any films or reports related to your condition with you on your initial visit.

Have you ever been treated by a Chiropractor before? ☐ Yes ☐ No If so, whom? ______________

Who is your Primary Medical Doctor? ______________Phone #: ______________

Lifestyle Information: Do you?

☐ Yes ☐ No smoke? ______________ packs/day
☐ Yes ☐ No exercise? How often? ______________
☐ Yes ☐ No take Vitamins or Supplements? (list below)
☐ Yes ☐ No take Medications? (list below)

☐ Yes ☐ No drink alcohol?______________ units/day
☐ Yes ☐ No wear heel lifts?
☐ Yes ☐ No wear orthotics?
☐ Yes ☐ No sleep well? How old is your mattress? __ yrs.

List all medications and/or supplements you take ______________

____

For Women:

☐ Yes ☐ No take Birth Control? ______________

☐ Yes ☐ No Are you Pregnant? Weeks/LMP__________?

Patient Medical Health History:

List any allergies to foods, medications, etc.: ____________________

List any condition(s) you have or ever had: ____________________

List any past accidents with dates: ____________________

List any previous surgeries/treatments with dates: ____________________

Symptoms Survey:

Do you currently have or have you ever had any of the following conditions or diseases?

- Yes No Neck Pain or Stiffness
- Yes No Mid Back Pain or Stiffness
- Yes No Lower Back Pain or Stiffness
- Yes No Tension or Migraine Headaches
- Yes No Tingling or Numbness in Arms / Hands
- Yes No Tingling or Numbness in Legs / Feet
- Yes No Shoulder / Elbow / Wrist Pain (Check)
- Yes No Hip / Knee / Ankle Pain (Check)
- Yes No High/Low Blood Pressure
- Yes No Difficulty Breathing
- Yes No Asthma
- Yes No Sinus Problems
- Yes No Spine Surgeries/Artificial Joints
- Yes No Heart Disease / Stroke / TIA (Check)
- Yes No Neurological Conditions
- Yes No Anemia
- Yes No Fainting/Seizures/Epilepsy
- Yes No Osteoporosis / Osteopenia
- Yes No Cancer, If yes, Please specify
- Yes No Chemotherapy / Radiation
- Yes No Alcohol / Drug Abuse
- Yes No Ulcers / Colitis
- Yes No Hepatitis
- Yes No Meningitis
- Yes No Diabetes/Tuberculosis
- Yes No Psoriatic Arthritis

Family Medical Health History:

Do any members of your immediate family have or ever had any medical conditions listed above? If yes, please list:

____

Insurance Information:

Insurance Co.Name: ____________________ Tel# ____________

Address: ____________________ City: ____________ State: ____ Zip: ______

Insured's Name: ____________________ Date of Birth: ____________

Insured's ID#: ____________________ Group #: ____________ Relationship ________

No-Fault/ Worker Comp Ins. Co: ____________________ Tel# ____________

Address: ____________________ City: ____________ State: ____ Zip: ______

Claim #: ____________________ WCB Case #: ____________ Date of Injury ________

I hereby authorize assignment of my insurance rights and benefits to be paid directly to the provider of services rendered at East Flushing Physica Therapy, PC (DBA Optimum Rehab P.C). It is the policy of some insurance companies to pay the subscriber (patient) directly in certain cases. fully understand that if I receive any payment directly from my insurance company for services rendered by any provider at Optimum Rehab P.C am solely responsible to sign over such insurance checks. In the event that I deposit these checks into my account or negotiate them, I am responsibl for reimbursing the provider that rendered these services for an equal amount.

Optimum Rehab P.C. requires all payments in full for services rendered at the time of the visit, unless other arrangements have been made with th business manager. If you want to discuss any financial matters, please inform the front desk prior to treatment.

We encourage you to inform the front desk if you want to discuss any questions you have regarding our services or billing practices. Thi promotes a greater confidence and trust between our patients and staff, thus resulting in a more comfortable experience and healin environment. I understand the information in this form and completed it truthfully to the best of my knowledge. I also understand that it is m responsibility to inform this office of any changes in the provided information that may occur in the future.

As the parent or legal guardian of the minor listed above, I hereby authorize the providers at this office and their assistants to administer care a necessary.

____________________ ____________________ ____________________

Patient's Signature Relationship Date