



New Patient Intake Form

Please fill out all questions thoroughly. Please Circle or mark "X" next to the YES/NO questions. If a question does not apply, please fill in the space with "No" or "None." Thank you.

Date: _____

PERSONAL INFORMATION

Last Name: _____ First Name: _____ MI _____

DOB: _____ Age: _____ Ethnicity: _____

Address: _____ City: _____

State: _____ ZIP: _____

Primary Phone #: _____ Alternate Phone #: _____

Email Address: _____

Occupation: _____ SSN# _____

Marital Status: _____ Spouse's Name: _____ Phone #: _____

Emergency Contact: _____ Relation: _____ Phone #: _____

How did you hear about this office? _____

Primary Physician _____ Physician Phone # _____

Insurance Provider Name _____ ID # _____

Have you ever visited a chiropractor before? _____

Are you taking and BLOODTHINNERS? (Xarelto, Pradaxa, Warfarin, Eliquis, Coumadin, etc.) _____

CHIEF COMPLAINT(S)

List the reason for today's office visit:

1.) _____

2.) _____

3.) _____

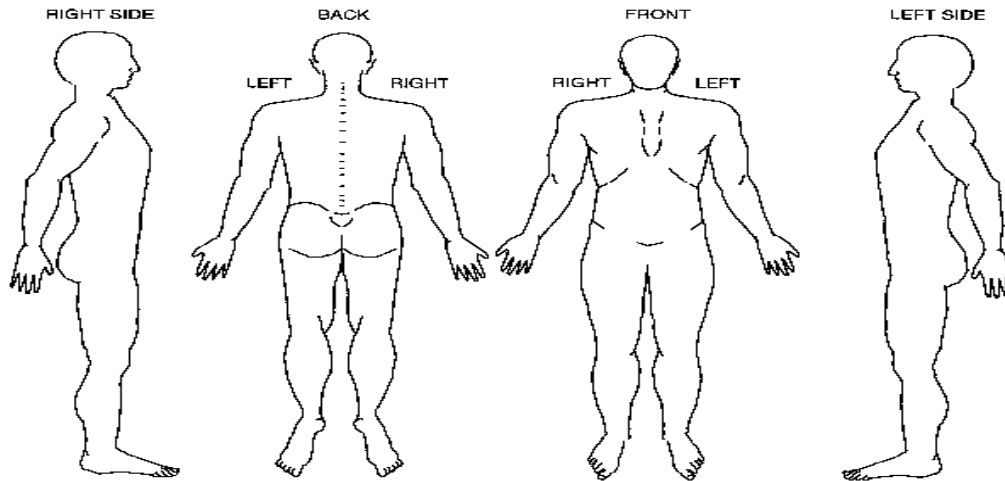
Were you hospitalized for any of these conditions? YES ___ NO ___

Have you received any imaging studies for any of the listed complaints? YES ___ NO ___

IN REGARDS TO THE MAIN COMPLAINT (#1 above):

Mark on the diagram where you pain is exactly if possible. Use the letter code listed:

A= Ache B= Burning N= Numbness P= Pins & Needles S= Stabbing X= Other



How long have you had this complaint? _____

When did it start? _____

Is this a new problem? _____

What makes your problem better? _____

What makes your problem worse? _____

On a 0-10 pain scale (0= no pain; 10= worst pain of your life), rate your pain now, and at its worst. _____

Is your pain constant or intermittent? _____

How does this problem affect your daily life? _____

Do you notice if your pain is worse at certain times of the day? _____

Have you seen another healthcare provider for this problem? _____

Have you been treated for this problem previously? _____

What treatment did you receive? _____

Did the treatment help? _____

In regards to your chief complaint or any prior complaint, have you ever had...

Night Sweats? YES___ NO___

Pain that wakes you up at night? YES___ NO___

Unexplained weight loss? YES___ NO___

Unexplained weight gain? YES___ NO___

Bowel/Bladder problems? YES___ NO___

Loss of sensation in the buttocks/inner thighs? YES___ NO___

Headaches? YES___ NO___

Recent Fever? YES___ NO___

Pain with no position of relief? YES___ NO___

Painful Urination? YES___ NO___

Blood in the urine/stool? YES___ NO___

GENERAL HISTORY INFORMATION



Height _____ Weight _____ Usual Weight _____

Lowest/highest weight in past 5 years: _____ / _____

Infections _____

History of Cancer _____

Recent Trauma _____

Hospitalizations? List when and why: _____

Current Medications? List here: _____

Current Vitamins/Supplements? List here: _____

Allergies of Food Sensitivities? List here: _____

Previous Surgeries or Operations? List type and date here: _____

History of sexually transmitted diseases? _____

Personal History of:

Cancer: YES _____ NO _____ If yes, list what type and when: _____

Diabetes: YES _____ NO _____ If yes, when was it diagnosed? _____

Heart Disease: YES _____ NO _____ If yes, when was it diagnosed? _____

Stroke: YES _____ NO _____ If yes, when? _____

History of eating disorders? List when and what: _____

FAMILY MEDICAL HISTORY

To the best of your knowledge, has your mother, father, siblings, or grandparents ever had any of the following conditions? If so, list who and the age of onset.

High cholesterol _____ Anxiety/Panic Attacks _____

Arthritis _____ Ulcerative Colitis _____

Alcoholism _____ Obesity _____

Thyroid Disease _____ Asthma _____

Heart Disease _____ Crohn's Disease _____

Kidney Disease _____ Hypertension _____

Osteoporosis _____ Eczema _____



Stroke _____ Autoimmune Disease _____
Cancer _____ Mental Illness _____
Allergies _____ Depression _____
Alzheimer's _____ Diabetes _____
Other: _____

SOCIAL HISTORY

Stress Level (highlight): None _____ Minimal _____ Moderate _____
High _____

Physical activity at work: None _____ Minimal _____ Moderate _____
High _____

Stressors? List what and rate on scale of 1-10: _____

How much sleep do you get per night? _____

Do you feel well-rested upon waking in the morning? _____

How many days per week do you exercise? _____

What type of exercise do you do? _____

Alcohol use? How often? How much? _____

Tobacco use? How often? How much? _____

Recreational drug use? _____

Sexual Activity? How many partners? _____

Please recall all of the food and drink you have eaten in the previous 24 hours.

Record amounts if possible:

Breakfast _____

Lunch _____

Dinner _____

Snacks/Other _____

Beverages: _____

Do you skip meals? YES _____ NO _____

If YES, explain further: _____

Do you have times where you eat uncontrollably? YES _____ NO _____

If YES, explain further: _____

Please mark if these apply:

Do you eat because you are:

_____ Lonely _____ Bored _____ Anxious _____ Stressed _____ Sad

_____ Depressed _____ Happy _____ Angry _____ Tired

Where do you eat?

_____ In the car _____ In bed _____ Watching TV _____ On the Computer

_____ Reading _____ Standing Up _____ Sitting Down _____ When not Hungry



REVIEW OF SYSTEMS

Please circle or highlight any of the symptoms you have had previously or presently, regardless of the chief complaint.

Constitutional:

- A. Recent weight change? _____
- B. Weakness, fatigue or chills? _____
- C. Convulsions? _____
- D. Fainting or Dizziness? _____
- E. Tremors? _____
- F. Difficulty Sleeping? _____
- G. Nausea? _____

Eyes:

- A. Difficulty seeing? _____
- B. Contact Lenses? _____
- C. Temporary loss of vision? _____
- D. Loss of or excessive tearing? _____

Ears, Nose, Throat:

- A. Dentures _____
- B. Problems with hearing? _____
- C. Hoarseness? _____
- D. Pain or lump in the front of the neck? _____
- E. Vision problems? _____
- F. Discharge? _____

Cardiovascular:

- A. Chest pain (heart pain, angina)? _____
- B. Known heart rhythm problems? _____
- C. Leaky heart valves? _____
- D. Problems with circulation? _____
- E. High or low blood pressure? _____

Respiratory:

- A. Chronic cough? _____
- B. Shortness of breath with exertion? _____
- C. Wheezing or asthma symptoms? _____
- D. Coughing up blood or mucus? _____
- E. Wheezing or chest pain? _____

Gastrointestinal:

- A. Constipation/ diarrhea? _____



- B. History of jaundice? _____
- C. Recent change in appetite? _____
- D. Blood per rectum? _____
- E. Frequent heartburn or indigestion? _____
- F. Hemorrhoids? _____
- G: Gall bladder issues? _____
- H. Vomiting /vomiting up blood? _____
- I. Bloating? _____
- J. Loss of appetite/excessive appetite? _____

Genitourinary:

- A. Frequent bladder infections? _____
- B. Frequent nighttime urination? _____
- C. Incontinence? _____
- D. Blood/pus in the urine? _____
- E. Kidney infection? _____

Musculoskeletal:

- A. Joint pain requiring medicine? _____
- B. Calf or leg pain with walking? _____
- C. Arthritis? _____
- D. Pain/numbness? Where? _____
- E. Joint Swelling? _____
- F. Hernia? _____

Skin:

- A. Rashes? _____
- B. Skin Cancers? _____
- C. Ulcers? _____
- D. Other major skin problems? _____
- E. Bruise easily? _____
- F. Varicose veins? _____

Neurological:

- A. TIA's or minor stroke? _____
- B. Recent numbness or weakness? _____
- C. History of seizures? _____
- D. History of concussions? _____

Psychological:

- A. Depression? _____
- B. Anxiety? _____
- C. Other psychiatric problems? _____
- D. Low energy levels? _____



E. Mood Swings? _____

F. ADHD/ADD? _____

Endocrine:

A. History of high or low blood sugar? _____

B. Thyroid problems? _____

Blood/Lymph:

A. Bleeding tendencies/bruising, or frequent nose bleeds? _____

B. Any history of anemia? _____

C. Do you have sickle cell disease? _____

Breasts:

A. Pain? _____

B. Discharge? _____

C. Other changes or abnormalities? _____

DATE OF LAST (and reason for test)...

A. Physical examination: _____

B. Blood test: _____

C. X-ray: _____

D. MRI: _____

E. Other imaging study: _____

F. Urine test: _____

FEMALES ONLY – Gynecological History:

A. Age of onset of menses: _____

B. Age of menopause: _____

C. Age at first pregnancy: _____

D. Number of children: _____

E. Last menstrual period: _____

F. Are you pregnant now? Yes_____ No_____

G. Is there a possibility you of becoming pregnant? Yes_____ No_____

H. Do you take birth control or have ever taken birth control? If yes, when and for how long? _____

I. Hot flashes? _____

J. Vaginal discharge? _____



NOTICE OF PRIVACY POLICIES

Effective Date: August 29, 2018

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact:

Dr. Vincent Esposito
3023 Quentin Road
Brooklyn, NY, 11234
917-268-7377
drvincentesposito@gmail.com

OUR LEGAL DUTY:

We are required by applicable federal and state law to maintain the privacy of your health information. We reserve the right to change our policy. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available. You may request a copy of our notice at any time. For more information about our privacy practices or for additional copies of this notice, please contact us using the information provided above.

USE AND DISCLOSURE OF HEALTH INFORMATION:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment for Services: We may use or disclose your health information to obtain payment for services provided to you.

Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, case management, review the competence of or qualification of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, and other activities.

Required By Law: We will disclose your health information about you when required to by federal, state, or local law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe you are a victim of abuse, neglect, or domestic violence, or other possible victim of other crimes. We may disclose this type of information to the extent necessary to avert serious threat to your health or safety or the health or safety of others.

Business Associate: We may disclose information to business associates who perform services on our behalf (such as billing companies), however we require them to appropriately safeguard your information.

Appointment Reminders: We may use or disclose your health information to contact you as a reminder (such as a voicemail, messages, email, postcards, or letters) that you have an appointment for treatment or medical care with Dr. Vincent Esposito.

PATIENT/CLIENT RIGHTS:

Access: You have the right to inspect and copy your health information, with limited exceptions. Submit your request in writing to Dr. Vincent Esposito. A fee will be charged for the costs associated with these requests. There are certain situations in which we are not required to comply with your request/. In these circumstances, we will respond to you in writing, stating why we will not grant your request and describe any rights you may have to request a review of our denial.

Disclosures Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain activities, for the last 6 years but not before the effective date listed above. If



you request an accounting more than once in a 12-month period, you will be charged a reasonable cost-based fee for responding to these requests.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended). We may deny your request under certain circumstances.

Restrictions: You have the right to request we place additional restrictions on our use of your health information. We are not required to agree to these additional restrictions, but if we do, we still abide by our agreement (except in an emergency).

Alternative Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request alternative communications, you must request it in writing. We will accommodate all reasonable requests.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this Notice at any time by contacting Dr. Vincent Esposito.

QUESTIONS AND COMPLAINTS:

If you want more information about our privacy policies or have questions or concerns, please contact us using the information provided above.

If you are concerned that we may have violated your privacy rights or disagree with a decision we made about access to your health information or in response to a request you may have made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may record a complaint to us by using the information provided at the beginning of this Notice. You may submit a request to the Secretary of the Department of Health and Human Services. We support the right to the privacy of your health information. If you file a complaint, we will not take any action against you or change our treatment of you in any way. We support the right to the privacy of your health information.

Your signature with date acknowledges that you have received and read Dr. Vincent Esposito's Notice of Privacy Practices.

Signature: _____

Relationship to Patient: _____

Print Name: _____

Date: _____



Office Payment Policies

1. Payment for services is due at the time services are rendered.
2. Assignment is accepted only from those insurance companies for which we are a provider.
3. You are responsible for obtaining a referral if your insurance policy requires one. You will not be seen if you do not have a referral. If you want to be seen without a referral from an insurance provider, you then agree to pay the amount agreed upon for the initial visit and/or for a follow-up visit.
4. If your insurance company denies coverage or payment, you are financially responsible for the visit.
5. If we are not a provider for your insurance, a superbill will be provided to you. You can submit the superbill to your insurance company for you to be reimbursed.
6. Payments can be made via cash, check, MasterCard, Visa, and American Express.
7. You will be responsible for the full fee of the appointment if you do not provide the office with twenty-four (24) hours' notice to cancel or change the appointment or if you do not show up for your appointment.
8. You will not be seen if you have an outstanding balance.
9. Outstanding balances after 60 days will be sent out to collection. When an account is sent out for collection, you are responsible for a 20% fee on the balance.

I have read, understand, and agree to these statements.

Signature _____ Date _____



Payment Policy Statement

Payment for services is due at the time services are rendered, unless other agreements have been made in advance. I accept major credit cards (Visa, Mastercard, American Express) through Paypal, Zelle, cash, and checks as forms of payment. If you are looking for a reimbursement claim from your insurance company, I will be happy to help with an insurance claim form, as I do not accept payments from third party providers directly. If your insurance company denies coverage, you are financially responsible for the payment of services provided.

By signing, I understand the payment policy and abide with the customs stated above.

Patient Signature _____ Date _____

Patient Name (Printed) _____