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____
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 of 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 manners 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 use 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 use 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. Member authorizes Inside Out Health & Wellness to charge the below credit card 6 monthly consecutive payments of $585 or a one-time charge of $3000 beginning with the date below for the member services set forth in this agreement. This agreement is non-transferable.
2. 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.
3. If your insurance company denies coverage or payment, you are financially responsible for the visit
4. 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.
5. Payments can be made via cash, check, or credit card (Visa, MasterCard, American Express) via PayPal.
6. You will be responsible for the full fee or the first payment twenty-four (24) hours prior to the first appointment's scheduled time.
7. You will not be seen if you have an outstanding balance.
8. 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 24 hours prior to the initial visit, unless other agreements have been made in advance. The payment will reserve your appointment time. This is done to ensure you receive the highest quality care possible. Your credit card will not be charged until 24 hours prior to the appointment. 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.

I choose to pay a one-time fee of $3,000_____

I choose to pay 6 monthly payments of $585_____

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

Payment Method: Visa_____ MasterCard_____ AMEX_____

Cardholder Name: _____
Credit Card Number: _____
Exp. Date: _____ Sec. Code: _____

Credit Card Billing Address & Zip Code if different than above:
_____

THE BELOW PARTIES HAVE EXECUTED THIS AGREEMENT FOR THE WRITTEN ABOVE

Vincent Esposito Digitally signed by Vincent Esposito Date: 2018.12.07 09:24:28 -05'00'
_____ Date_____
Signature of Dr. Vincent Esposito

_____ Date_____
Client Signature