Welcome to our office.

DATE:_____

Confidential Patient Case History

Complete ALL parts to this questionnaire. This confidential history will be part of your permanent record.
Thank You.

Patient Information:

Patient Name: _____ DOB: ___/___/___ Sex: M F

If under the age of 18, Parent/Guardian Name: _____

Address: _____ City: _____ Zip: _____

_____ Marital Status: S M D W Children Ages:_____

Home Phone (___) _____ Cell Phone (___) _____ Work Phone (___)_____

E-mail Address: _____

Occupation: _____ Employer: _____

How did you hear about our office? _____

Who referred you to our office? _____

Patient Condition:

Reason for THIS visit: _____

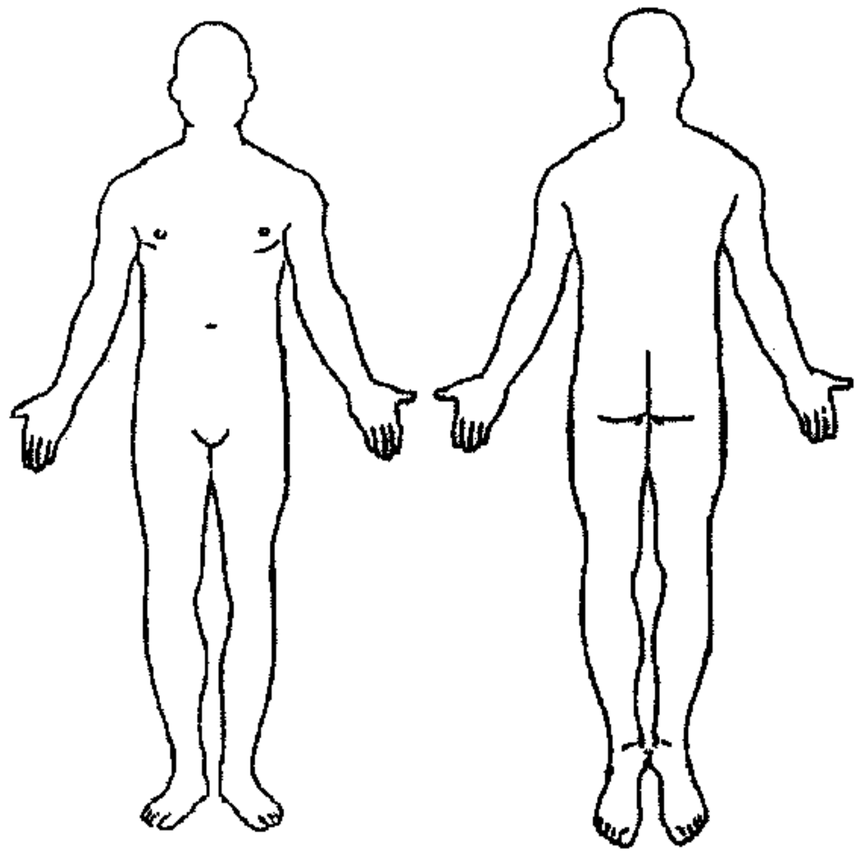
When did your symptoms appear? _____ Is this condition getting progressively worse? Y N

Any other Health Care providers treating you for this? _____

Rate the severity of your pain from 1 (least pain) to 10 (severe pain): _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

Mark an "**X**" on the picture where you continue to have pain or tightening:



How often do you have this pain? (Please mark all that apply)
☐ Constant ☐ Come and go ☐ Daily
☐ Weekly ☐ Wake up ☐ End of day

Does it interfere with your:
☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities that are painful to perform:
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Laying down

What treatment have you already received for your condition? ☐ Medication ☐ Surgery

☐ Physical Therapy ☐ Chiropractic ☐ Other _____

What other doctor(s) have treated you for this condition? _____

MRI: _____ X-ray: _____

Place an **X** on "**Yes**" or "**No**" to indicate if you have or have had any of the following:

Diabetes	Yes	No	High Cholesterol	Yes	No	Polio	Yes	No
Emphysema	Yes	No	Kidney Disease	Yes	No	Prostate Problem	Yes	No
Epilepsy	Yes	No	Liver Disease	Yes	No	Psychiatric Care	Yes	No
Fractures	Yes	No	Migraines	Yes	No	Rheumatoid Arthritis	Yes	No
Goiter	Yes	No	Mononucleosis	Yes	No	Stroke	Yes	No
Heart Disease	Yes	No	Multiple Sclerosis	Yes	No	Thyroid Problems	Yes	No
Hepatitis	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Hernia	Yes	No	Pacemaker	Yes	No	Tumor	Yes	No
Headaches	Yes	No	Parkinson's Disease	Yes	No	Ulcers	Yes	No
Herniated Disc	Yes	No	Pinched Nerve	Yes	No	Other _____		

EXERCISE
- None
- Moderate
- Daily
- Heavy

WORK ACTIVITY
- Sitting
- Standing
- Light Labor
- Heavy Labor

HABITS
- Smoking — Packs/Day _____
- Alcohol — Drinks/Week _____
- Coffee/Caffeine Drinks — Cups/Day _____
- High Stress Levels — Reason _____

MEDICATIONS

_____

_____

_____

ALLERGIES

_____

_____

_____

VITAMINS

_____

_____

_____

Are you pregnant? Yes No If Yes, due date: _____

Injuries/Surgeries you have had:

	Description	Date
Falls	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

☐ Cash ☐ General Health Insurance ☐ No-Fault Insurance ☐ Worker's Comp. Insurance

General Health Insurance:

Insurance Company Name: _____ Phone #: _____

ID#: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Secondary Health Insurance:

Insurance Company Name: _____ Phone #: _____

ID#: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

I hereby authorize this office to release any information requested by my insurance company to document any claim for benefits. I understand that I am responsible for full payment of all charges for my treatment. Services are payable at the time rendered.

_____ _____

Patient or Guardian Signature Date

PRIVACY PRACTICES ACKNOWLEDGEMENT

Durlan Castro, D.C., P.C.
Active Release Techniques Provider/Instructor
350 Veterans Memorial Highway
Commack N.Y 11725
Phone (631)486-9100 Fax (631)486-9102

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by: _____

Printed Name – Patient or Representative

_____

Signature Date

Witness: _____

Printed Name – Practice Representative

_____

Signature Date