AMBER STONE MEDICAL, P.C.
115 Broadhollow Road, Suite 10, Melville, NY 11747
631-990-HEKA (4352) | info@hekahealthandwellness.com

PATIENT INTAKE FORM

Today's Date: ____ /____ / _____ ☐ New Patient ☐ Established patient, updated

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided with a copy of the Amber Stone Medical, P.C. Notice of Privacy Practice ☐Yes

PATIENT INFORMATION

Patient's Full Name _____ (MI)_____

DOB _____ Age _____Gender _____

Address _____

City _____ State_____ Zip _____

Email Address _____

Primary Phone Number _____ Secondary Phone _____

Employer_____

Preferred Method of Contact _____

Are you seeing us as the result of a car accident or work accident? _____

INSURANCE INFORMATION

Primary Insurance Carrier _____ ID# _____

Policy Holder's name (if someone else)_____

Policy Holder's DOB _____

Policy Holder's Relationship to Patient _____

Policy Holder's Phone Contact Number _____

REFERRAL INFORMATION

How did you hear about us? _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name_____ Relationship _____

Primary Contact Number _____ Secondary Contact Number _____

CHIEF COMPLAINT: Do you have?

Neck pain	☐ Yes ☐ No	Shoulder pain	☐ Yes ☐ No
Arm pain	☐ Yes ☐ No	Upper back pain	☐ Yes ☐ No
Hip/Leg	☐ Yes ☐ No	Any other complaints	_____

If more than one area, which is worse? _____

How long have you had this problem? _____

Did your symptoms follow an injury? _____ If yes; _____

☐ at work ☐ auto accident ☐ Other/Describe: _____

Your least and greatest pain levels over the past two weeks:

(None) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Severe)

Describe your pain (Check all that apply)

☐ Constant	☐ Deep	☐ Dull	☐ Sharp
☐ Intermittent	☐ Throbbing	☐ Stiffness	☐ Aching
☐ Shooting	☐ Cramping	☐ Burning	☐ Stabbing

Is your pain worse (check one)

☐ At night	☐ In the mornings	☐ At the end of the shift/day
☐ No difference between day and night		☐ On a wet/cold day

Indicate which of the following activities increases (I) or decreases (D) your pain

When I first get out of bed getting up	☐ I	☐ D	Long car rides	☐ I	☐ D
Sitting	☐ I	☐ D	Standing	☐ I	☐ D
Lying on my back/side	☐ I	☐ D	Walking	☐ I	☐ D
Leaning forwards	☐ I	☐ D	Bending back	☐ I	☐ D
Lifting/bending forwards	☐ I	☐ D	Lying on stomach	☐ I	☐ D
Straining	☐ I	☐ D	Coughing/Sneezing Twisting	☐ I	☐ D
Look up/turn head sideways	☐ I	☐ D	Reaching over Washing/combing hair	☐ I	☐ D
Climbing stairs/walking up ramp	☐ I	☐ D	Going down stairs/ramp	☐ I	☐ D

Other _____

Have you bad neck/back symptoms before? ☐ Yes ☐ No

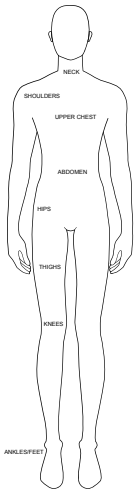
Have you ever had previous back or neck surgery? ☐ Yes ☐ No

If yes, describe:._____

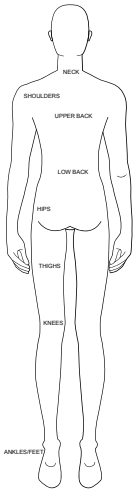
Have you had prior episodes of back symptoms for which you received Worker's Compensation or No-Fault? ☐ Yes ☐ No

Check appropriate areas of your body where you NOW feel your typical pain. Include all affected areas.

(Check all that apply)



FRONT SIDE	YES	NO	LEFT	RIGHT	BOTH	PAIN	NUMBNESS
Neck	☐	☐	☐	☐	☐	☐	☐
Shoulders	☐	☐	☐	☐	☐	☐	☐
Upper back	☐	☐	☐	☐	☐	☐	☐
Low back	☐	☐	☐	☐	☐	☐	☐
Hips	☐	☐	☐	☐	☐	☐	☐
Thighs	☐	☐	☐	☐	☐	☐	☐
Knees	☐	☐	☐	☐	☐	☐	☐
Ankles/feet	☐	☐	☐	☐	☐	☐	☐



BACK SIDE	YES	NO	LEFT	RIGHT	BOTH	PAIN	NUMBNESS
Neck	☐	☐	☐	☐	☐	☐	☐
Shoulders	☐	☐	☐	☐	☐	☐	☐
Upper back	☐	☐	☐	☐	☐	☐	☐
Low back	☐	☐	☐	☐	☐	☐	☐
One or both hips	☐	☐	☐	☐	☐	☐	☐
One or both thighs	☐	☐	☐	☐	☐	☐	☐
One or both knees	☐	☐	☐	☐	☐	☐	☐
One or both ankles/feet	☐	☐	☐	☐	☐	☐	☐

Please list previous radiology studies you have had for this problem.

	Date	Location
MRI		
CT Scan		
Myelogram		
Bone Scan		
EMG		
X rays		

PREVIOUS TREATMENT

Put a check next to each type of treatment you have had for your back/neck in the past.

Then check the column that best describes the effect of the treatment. (Check all that apply)

TREATMENT	BETTER	WORSE	NO CHANGE
Hot packs/ice	☐	☐	☐
Ultrasound	☐	☐	☐
Massage	☐	☐	☐
TENS/Electrical Stimulation	☐	☐	☐
Yoga/Tai-Chi	☐	☐	☐
Exercises	☐	☐	☐
Traction/DRS	☐	☐	☐
Bed Rest	☐	☐	☐
Pool therapy	☐	☐	☐
Biofeedback	☐	☐	☐
Injections	☐	☐	☐
Braces/Splints	☐	☐	☐
Medication	☐	☐	☐
Acupuncture	☐	☐	☐
Chiropractic Adjustments	☐	☐	☐

MEDICAL HISTORY Have you ever had: (Check all that apply)

- ☐ AIDS or HIV testing
- ☐ Asthma/Breathing problems
- ☐ Cancer
- ☐ Radiation/Chemotherapy
- ☐ Migraine or other severe head pain
- ☐ High Blood Pressure
- ☐ Chronic Fatigue Syndrome
- ☐ Phlebitis or Blood clots
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Kidney Infections
- ☐ Heart Attack
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Kidney Stones
- ☐ Arthritis
- ☐ Seizures
- ☐ Ulcer
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Other:

PAST SURGICAL HISTORY

Year	Operation	Place Hospitalized

If you had previous back surgery; What were your symptoms before the surgery?

Indicate (L) for left side, (R) for right side, (B) for both sides and check all that applies

Neck pain	☐ L ☐ R ☐ B	Urinary complaints	☐ Y ☐ N
Arm pain/numbness/weakness	☐ L ☐ R ☐ B	Bowel complaints	☐ Y ☐ N
Back pain	☐ L ☐ R ☐ B	Walking/gait disturbances	☐ Y ☐ N
Leg pain/numbness/weakness	☐ L ☐ R ☐ B	Impotence	☐ Y ☐ N
Arm pain/numbness/weakness	☐ L ☐ R ☐ B	Balance/falls/clumsiness	☐ Y ☐ N
Shoulder pain/numbness/weakness	☐ L ☐ R ☐ B		
Wrist/hand pain/numbness	☐ L ☐ R ☐ B		
Hip/buttock/thigh pain/numbness/weakness	☐ L ☐ R ☐ B		
Ankle/foot pain/numbness/weakness	☐ L ☐ R ☐ B		

Did your symptoms improve after surgery?_____ If yes, how long afterwards? _____

Did you get worse after surgery? _____ If yes, explain: _____

Were you released back to work after surgery? _____ If so, when?_____

ALLERGIES

Name of medicine/substance	Type of reaction	Date

MEDICINES List all medicines that you have taken recently. Include vitamins and nonprescription medicine.

FAMILY HISTORY

Spinal Problems	☐ Yes	☐ No	If yes, describe _____
Bleeding Disorders	☐ Yes	☐ No	If yes, describe _____
Heart Disease	☐ Yes	☐ No	If yes, describe _____
Cancer	☐ Yes	☐ No	If yes, describe _____
Diabetes	☐ Yes	☐ No	If yes, describe _____

SOCIAL HISTORY How many years of schooling? (Check all that apply)

☐ Less than high school ☐ High School Graduate ☐ Technical School Diploma ☐ 1-3 years of college

☐ College Graduate ☐ Post Graduate or Professional Degree

MARITAL STATUS

☐ Single ☐ Married ☐ Divorced ☐ Remarried ☐ Widowed ☐ Separated

How many years?_____ Number of children?_____ Ages:_____

Who lives with you at home? _____

WORK STATUS

☐ Working ☐ Not Working ☐ Student ☐ Disabled ☐ Retired

Primary Occupation; _____ Employer: _____

How long have you worked at your present job; _____ If not working, last date worked: _____

Spouse's Occupation;_____ Employer: _____

Have you ever smoked_____ Type/Amount: _____

If quit, when? _____ Have you used Marijuana:_____

Amount of alcohol consumed in a typical week? _____ Have you used Cocaine: _____

Cups of caffeine drinks per day? _____ Have you used Heroin: _____

Do you get any regular exercise? _____ Type of exercise: _____

REVIEW OF SYSTEMS (Check all that apply)

CONSTITUTIONAL

- ☐ Fever
- ☐ Chills
- ☐ Night sweats
- ☐ Weight loss
- ☐ Loss of appetite

ALLERGY/IMMUNE

- ☐ Drug allergy
- ☐ Seasonal allergy
- ☐ Food allergy
- ☐ Iodine allergy
- ☐ Transplant

NEUROLOGIC

- ☐ Paralysis
- ☐ Tremors
- ☐ Spasticity
- ☐ Seizures
- ☐ Muscle atrophy
- ☐ Double vision

MUSCULOSKELETAL

- ☐ Joint stiffness/swelling
- ☐ Muscle pain/swelling
- ☐ Fatigue
- ☐ Fractures

HEMO-LYMPHATIC

- ☐ Anemia
- ☐ Excessive bleeding
- ☐ Easy bruising
- ☐ Lymphoma
- ☐ Leukemia
- ☐ Cancer
- ☐ Lymph node swelling

CV/RESPIRATORY

- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough
- ☐ Coughing up blood
- ☐ Chest pains
- ☐ Palpitations
- ☐ Leg swelling

GI

- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Nausea/vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Stomach pain

ENDOCRINE

- ☐ Obesity
- ☐ Thyroid disorder
- ☐ Diabetes
- ☐ Menopause
- ☐ Menstrual irregularities
- ☐ Pelvic Pain
- ☐ Addison's disease

HENT

- ☐ Loss of vision
- ☐ Eye redness
- ☐ Headaches
- ☐ Dizziness
- ☐ Glaucoma

SKIN/INTEGUMENTARY

- ☐ Rash
- ☐ Ulcer
- ☐ Eczema
- ☐ Hives

GU

- ☐ Pain urinating
- ☐ Incontinence
- ☐ Blood in urine
- ☐ Dribbling
- ☐ Sexual Difficulties
- ☐ Pregnant ☐ LMP___

PSYCHIATRIC

- ☐ Poor sleep
- ☐ Depression
- ☐ Anxiety
- ☐ Stress at work/home
- ☐ Panic spells

HEKA
Health & Wellness

NO SHOW / LATE CANCELLATION POLICY

The Office of Heka Health & Wellness is committed to meeting all of our patients' wellness needs.

PLEASE be advised of the following Policy:

All appointments must be cancelled 24 hours before your appointment or 48 hours before a Monday appointment to avoid incurring a no-show or late cancellation fee charged to you.

PLEASE NOTE: Insurance does **NOT** cover no-show or late cancellation fees. The patient will be responsible for payment.

A no show/cancellation fee of **$25.00** will be charged to you if an appointment is either missed or not cancelled.

Signature: _____ Date: _____

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