Dr. Gary Olson
Long Island Spine & Sports Injury Center

Patient Information

Name: _____ **Sex:** _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Cell Phone:** _____ **Marital Status:** _____

Email Address: _____

Employer: _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Referred By: _____ ☐ Doctor ☐ Friend ☐ Relative ☐ Other: _____

Emergency Contact Person: _____ **Phone:** _____

Relationship to patient: _____

Insurance Information

Policy Holder Name: _____ **Sex:** _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Marital Status:** _____ **Relationship to Patient:** _____

Insurance Carrier: _____ **Insurance ID:** _____

Cancellation Policy

We want to thank you for choosing us as your health care provider. In order to provide you and our other patients with the best optimal care, we request that you follow our guidelines regarding missed and/or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses – you, the doctor and other patients that would like to have utilized your appointment time.

The charge for missed or cancelled appointments with failure to provide 24 hours notice is $30.00; please realize how important it is to keep your reserved time. Thank you for your consideration of our policies and for the opportunity to be your health care office of choice.

Patient Health Intake

Patient Name: _____ **Date:** _____ **Age:** _____

1. ***When* did symptoms begin?** _____

2. **Describe your symptoms**: _____

3. **Have you had any recent traumas in the last 6 months**? _____

4. **How were you injured**?

☐ No specific injury ☐ Slip & Fall ☐ Fell down stairs ☐ Hit head
☐ Work Injury ☐ Fell from a height ☐ Lifting injury ☐ Hit by an object
☐ Automobile Accident ☐ Trip & Fall ☐ Twisting injury ☐ Hit head & lost consciousness
☐ Other:

5. **What treatment have you received**? ☐ No treatment

☐ Physical therapy ☐ Chiropractic care ☐ Lumbar corset brace ☐ Other: _____
☐ Epidural Steroid ☐ Nerve blocks ☐ Trigger point injections _____
☐ Injection ☐ Cervical Collar ☐ Extremity brace

Where did you go for treatment? _____ **Was prior treatment helpful?** ☐ Yes ☐ No

When was your last bone scan? _____

What radiology tests have you had? ***X-rays*** *date*: _____ ***MRI*** *date*: _____ ***CT Scan*** *date*: _____
area(s) tested: _____ _____ _____

6. **Are you involved in any litigation/lawsuit related to your injuries?** ☐ Yes ☐ No

7. **Mark all medication types you have taken related to your injuries for today's visit:**

☐ Anti-Inflammatory ☐ Oxycontin ☐ Darvocet ☐ Norco ☐ Meloxacam
☐ Sleeping Aides ☐ Ultram ☐ Flexeril ☐ Celebrex ☐ Other:
☐ Narcotic ☐ Relpax ☐ Protonix ☐ Tramadol
☐ Muscle relaxants ☐ Tylenol ☐ Percocet ☐ Flector patch
☐ Medicated patches ☐ Motrin ☐ Ibuprofen ☐ Benicar
☐ Anti convulsants ☐ Valium ☐ Endocet ☐ Coumadin
☐ Vicoden ☐ Aleve ☐ Neurontin ☐ Cyclobenzeprene

8. **Surgeries related to today's complaint:** ☐ No surgeries related to today's complaint

☐ Cervical Laminectomy ☐ Posterior cervical surgery ☐ Right wrist surgery
☐ Cervical Fusion ☐ Anterior cervical surgery ☐ Left wrist surgery
☐ Lumbar Fusion ☐ Left hip surgery ☐ Other: _____
☐ Lumbar Laminectomy ☐ Right hip surgery _____
☐ Thoracic Laminectomy ☐ Left shoulder surgery _____
☐ Thoracic Fusion ☐ Right shoulder surgery

9. **Indicate your level of pain:** *Mild* 1☐ 2☐ 3☐ *Moderate* 4☐ 5☐ 6☐ *Severe* 7☐ 8☐ 9☐ *Unbearable* 10☐

10. **Mark all words that best describe you symptoms:**

☐ Shooting ☐ Burning ☐ Constant ☐ Radiating
☐ Throbbing ☐ Numbing ☐ Dull ☐ Hypersensitive
☐ Torturing ☐ Nagging ☐ Aching ☐ Other:
☐ Sharp ☐ Cramping ☐ Intermittent _____

11. **What aggravates your condition?**

☐ Standing ☐ Walking ☐ Touching affected area ☐ Other:
☐ Bending ☐ Sexual activity ☐ Moving from sitting to standing position
☐ Emotional stress ☐ Menstruation
☐ Sleeping ☐ Sitting

12. **Has your problem decreased or prevented your ability to exercise?** ☐ Yes ☐ No

13. **Family History:**

☐ Rheumatoid Arthritis ☐ High Blood Pressure ☐ High Cholesterol ☐ Diabetes
☐ Depression ☐ Heart Disease ☐ Cancer ☐ Chronic pain

14. **Are you working?** ☐ Yes ☐ No

15. **What best describes your type of work?** ☐ Retired ☐ Not Employed

☐ Sedentary Duty- Occasionally lifting/carrying small items [10 lbs max]. Walking and standing required occasionally
☐ Light Duty-Frequent lifting [20 lbs max] & carrying[10 lbs max] Significant walking/standing w. sitting pushing & pulling
☐ Medium Duty- Lifting [50 lbs max] with frequent lifting/carrying of objects [25 lbs max]
☐ Heavy Duty- Lifting [100 lbs max] with frequent lifting/carrying of objects [50 lbs max]
☐ Very Heavy Duty- Lifting [Heavier than 100 lbs] with frequent lifting/carrying of objects [Heavier than 50 lbs]

16. **Do you drink alcohol?** ☐ Never ☐ Occasionally ☐ Socially ☐ Frequently

17. **Have you ever had substance abuse treatment?** ☐ Yes ☐ No

18. **Do you use tobacco?** ☐ No ☐ Yes If yes, how much: _____ **packs per day**
Former smoker? If yes, **Packs per day**:_____ **Years Smoked**: _____ **Quit Date**:_____(year)

19**. List all current medications**:

20. **Indicate any allergies:** ☐ No known allergies

☐ Iodine ☐ Tape ☐ Ultram ☐ Sulfa ☐ Erythromycin
☐ Codeine ☐ Steroids ☐ Darvocet ☐ Penicillin ☐ NSAIDS- anti-
☐ Latex ☐ Betadine ☐ Hydrocodone ☐ Morphine ☐ inflammatories
☐ Other:

21. **Indicate all past and present medical health problems:** ☐ I am in good health

☐ Diabetes ☐ Mitral valve prolapse ☐ Arthritis
☐ Lung disease ☐ High cholesterol ☐ Osteoporosis
☐ Stomach problems ☐ Heart problems ☐ Rheumatoid arthritis
☐ Ulcer disease ☐ Asthma ☐ Other:
☐ Kidney disease ☐ Bleed easily

22. **Indicate all past surgeries:** ☐ No history of surgical procedures

☐ Amputation ☐ Abdominal aortic aneurysm repair ☐ Sinus surgery
☐ Angioplasty ☐ Appendectomy bowel resection ☐ Thoracic post laminectomy
☐ Cataract surgery ☐ Femoral popliteal bypass ☐ Ventriculoatrial shunt
☐ Breast biopsy ☐ Hiatal hernia repair ☐ Ventriculoperitoneal shunt
☐ Bypass ☐ Incisional hernia repair ☐ Colonoscopy
☐ Carotid endarterectomy ☐ Inguinal hernia repair ☐ Endoscopy
☐ Anterior cervical discectomy & fusion ☐ Umbilical hernia repair ☐ Resection of pulmonary tissue
☐ Lumbar laminectomy ☐ Laparoscopic cholecystectomy
☐ Cervical post laminectomy ☐ Lumbar post laminectomy ☐ Prostate biopsy
☐ Cholecystectomy ☐ Lumbar Discectomy ☐ Stent replacement
☐ Colon resection ☐ Lumbar fusion ☐ Left carpal tunnel release
☐ Cervical laminectomy ☐ Mastectomy ☐ Right carpal tunnel release
☐ Hysterectomy ☐ Oopherectomy ☐ Left knee arthroscopy
☐ Gastrectomy ☐ Pacemaker ☐ Right knee arthroscopy
☐ Laparoscopy ☐ Renal Transplant ☐ Other:
☐ Cystectomy ☐ Rhinoplasty
☐ Salpingectomy

23. **Do you have any ill feelings?** ☐ No ill feelings

☐ Fever ☐ Night sweats ☐ Weight gain ☐ Uncontrolled sweating
☐ Chills ☐ Loss of appetite ☐ Loss of energy
☐ Fatigue ☐ Weight loss ☐ Decreased activity level

24. **Do you have any mental health problems?** ☐ No mental health problems

☐ Irritability ☐ Depression ☐ Disturbed sleep ☐ Suicidal thoughts ☐ Anxiety ☐ Nervousness

25. **Do you have any trouble urinating?** ☐ No trouble urinating

☐ Frequent urination ☐ Trouble starting/stopping stream ☐ Sexual dysfunction
☐ Urgency ☐ Burning with urination ☐ Hesitancy
☐ Nocturia ☐ Losing control/incontinence
☐ Erectile dysfunction ☐ Bowel dysfunction

26. **Do you have trouble with your vision?** ☐ No trouble with vision

☐ Blurred vision ☐ Double vision ☐ Vision loss ☐ Eye pain ☐ Work glasses/contacts

27. **Do you have any symptoms of heart trouble?** ☐ No symptoms of heart trouble

☐ Chest pain ☐ Palpitations ☐ Fainting ☐ Shortness of breath ☐ Ankle swelling

28. **Do you have breathing problems?** ☐ No breathing problems

☐ Coughing ☐ Wheezing ☐ Shortness of breath

29. **Do you have stomach problems?** ☐ No stomach problems

☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Loss of bowel control

30. **Do you have muscle or joint problems?** ☐ No joint problems

☐ Joint pain ☐ Joint weakness ☐ Muscle weakness

31. **Do you have any skin problems?** ☐ No skin problems

☐ Rash ☐ Itching ☐ Dryness ☐ Lesions ☐ Open wound/infection ☐ Hair/nail changes

32. **Do you have any immunity problems?** ☐ No immunity problems

☐ Enlarged lymphnodes ☐ Hives ☐ Hay fever ☐ Persistent infections

33. **Do you have any endocrine problems?** ☐ No endocrine problems

☐ Diabetes ☐ Thyroid disorder

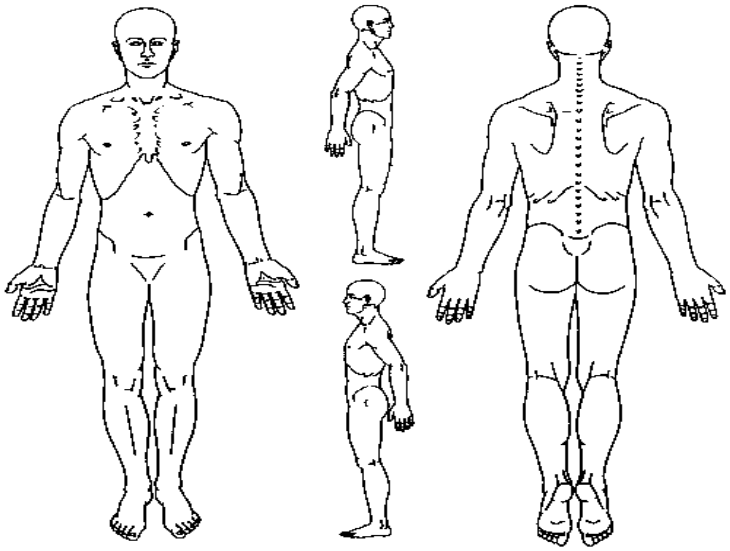
34. **Do you have any neurological problems?** ☐ No neurological problems

☐ Seizures ☐ Abnormal sensory feelings in extremity ☐ Loss of memory

35. **Do you have bruising or bleeding problems?** No bruising or bleeding problems

☐ History of anemia ☐ Abnormal bleeding ☐ Bruising ☐ Heat intolerance ☐ Cold intolerance

Indicate on the diagram below where you are having pain or other symptoms:



Oswestry

Patient Name: _____Date:_____

Please answer every section by marking the one statement that best applies to you.

Pain Intensity
- ☐ The pain is mild and comes and goes.
- ☐ The pain is mild and does not vary much.
- ☐ The pain is moderate and comes and goes.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain is severe and comes and goes.
- ☐ The pain is severe and does not vary much.

Personal Care (Washing, Dressing, etc.)
- ☐ I do not have to change the way I wash and dress.
- ☐ I do not change my habits, it causes some pain.
- ☐ I do not change my habits, it increases pain.
- ☐ Changed habits, pain increased.
- ☐ Unable to do some personal care without help.
- ☐ Unable to wash or dress without help.

Lifting
- ☐ I can lift heavy weights without increased pain.
- ☐ I can lift heavy weights but it increases pain.
- ☐ Cannot lift heavy weights off the floor.
- ☐ Can lift heavy weights from a table.
- ☐ Can lift weights from a table.
- ☐ Can only lift very light weights.

Walking
- ☐ I have no pain when walking.
- ☐ Cannot walk more than one mile.
- ☐ Cannot walk more than 1/2 mile.
- ☐ Cannot walk more than 1/4 mile.
- ☐ Can walk only with crutches.
- ☐ Bedridden and must crawl to the toilet.

Sitting
- ☐ Sitting does not cause me any pain.
- ☐ Can only sit as long as I like in favorite chair
- ☐ Pain prevents me from sitting over 1 hour.
- ☐ Pain prevents me from sitting over 1/2 hour.
- ☐ Can sit no longer than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Standing
- ☐ Can stand unlimited time without increased pain.
- ☐ Can stand as long as I want with some pain.
- ☐ Cannot stand longer than 1 hour.
- ☐ Cannot stand longer than 1/2 hour.
- ☐ Cannot stand longer than 10 minutes.
- ☐ Cannot stand at all.

Sleeping
- ☐ I get no pain when I am in bed.
- ☐ I get pain in bed, but sleeps well.
- ☐ Normal sleep reduced by 1/4.
- ☐ Normal sleep reduced by 1/2.
- ☐ Normal sleep reduced by 3/4.
- ☐ Pain prevents me from sleeping at all.

Traveling
- ☐ I get no increased pain when traveling.
- ☐ Travel causes some pain, but not made worse.
- ☐ Causes extra pain, no change in form or travel.
- ☐ Increases pain/seeks alternative forms of travel.
- ☐ Cannot travel unless I am lying down.
- ☐ My pain restricts all forms of travel.

Social Life
- ☐ My social life is normal and causes no pain.
- ☐ My social life is normal, but causes extra of pain.
- ☐ Pain limits energetic interests.
- ☐ Pain prevents me from going out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of my pain.

Changing degree of pain
- ☐ Pain is rapidly improving.
- ☐ Pain fluctuates but is improving.
- ☐ Improvement is slow.
- ☐ Pain level is unchanged.
- ☐ Pain is gradually worsening.
- ☐ Pain is rapidly worsening.

Signature of Patient or Authorized Representative **Print Name** **Date**

Guarantee Agreement

I. Individual's responsibility for non-covered services:

In consideration of services rendered by Dr. Gary Olson D.C., P.C., to the undersigned patient, the undersigned promise(s) to pay to Dr. Gary Olson, any copayment, co-insurance, deductible or other charges required to be paid by my health insurance coverage. In addition, I promise to pay for all services that are not covered by my health insurance plan. In the case of denial or termination of benefits, or in the event I fail to inform you of any changes in my insurance coverage, I, the undersigned, understand that I am responsible for payment in full for services rendered.

In the case of denial from No-Fault, the Workers' Compensation Board, Workers' Compensation carrier or termination of my chiropractic benefits, I, the undersigned, am responsible for payment in full of any and all services rendered.

I, the undersigned, understand that I am responsible for payment in full for services rendered, in the event that I fail to receive a referral from my primary care physician, when required by my health plan.

It is, however, expressly understood that there will be no obligation of the undersigned to pay for any services, which are improperly billed.

II. Authorization to Release Records:

I hereby authorize Dr. Gary Olson to release to my insurer, government agencies, or to whomever if financially responsible for my medical care, all information needed to substantiate payment for such medical care and, if required, of precertification/prior approval purposes.

Signature of Patient or Authorized Representative **Print Name** **Date**

HIPAA Privacy Laws

Uses and disclosures

Treatment. Your health information may be used to staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated.

Health Care Option. Your health information may be used as necessary to support the day-to-day activities and management of Dr. Gary Olson. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and ensure quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department. Other uses and disclosures require your specific authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information. Appointment reminders. Your information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send your information describing other health-related products and services that we believe may interest you.

Individual Rights. You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure or your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to receive an accounting of how and whom your protected health information had been disclosed.
- The right to receive a printed copy of this notice.

Dr. Gary Olson is required by law to maintain privacy of your protected health information and to provide you with this notice of privacy practices.

Right to review Practices. As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations upon request, we will provide.

Request to Inspect Protected Health Information. You may generally inspect or copy your protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing to the office manager. Your request will be reviewed and will generally be approved, unless there are legal or medical reasons to deny the request.

Complaints. If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Gary Olson, D.C.
285-10 Commack Rd.
Commack, NY 11725

Signature of Patient or Authorized Representative **Print Name** **Date**