Warwick Brain & Spine Therapy
Dr. Calvin Hargis, Board Certified Chiropractic Orthopedist

40 Maple Avenue, Route 94
Warwick, NY 10990
845-986-5500

PATIENT INFORMATION SHEET

NAME: _____

ALLERGIES - Please Check

- ☐ Animals
- ☐ Aspirin/Pain Medication
- ☐ Bee Stings
- ☐ Chocolates/Sweets
- ☐ Dairy (milk, cheese)
- ☐ Dust
- ☐ Eggs
- ☐ Latex
- ☐ Molds
- ☐ Penicillin
- ☐ Ragweed/Pollen
- ☐ Rubber
- ☐ Seasonal Allergies
- ☐ Shellfish
- ☐ Soaps
- ☐ Wheat
- ☐ X-Ray Dye

ALLERGIES TO ANY MEDICATIONS - Please list:

_____

SURGERIES - Please Check

- ☐ Appendix
- ☐ Back
- ☐ Carpal Tunnel
- ☐ Cervical Disc
- ☐ Chest
- ☐ Disc
- ☐ EENT
- ☐ Elbow
- ☐ Foot
- ☐ Gallbladder
- ☐ Gastrointestinal
- ☐ Gynecological
- ☐ Heart Bypass
- ☐ Hernia
- ☐ Hip
- ☐ Hip Replacement
- ☐ Knee
- ☐ Knee Replacement
- ☐ Lumbar Disc
- ☐ Neck
- ☐ Neurological
- ☐ Obstetrical
- ☐ Shoulder
- ☐ Thoracic Disc
- ☐ Wrist
- ☐ Wrist/Hand
- ☐ Other

MEDICAL HISTORY - Please Check or Mark "BR" for blood relative

You	BR		You	BR		You	BR		You	BR	
☐	☐	Ankle Pain	☐	☐	Arm Pain	☐	☐	Arthritis	☐	☐	Asthma
☐	☐	Back Pain	☐	☐	Broken Bones	☐	☐	Cancer	☐	☐	Chest Pain
☐	☐	Depression/Other Disorder	☐	☐	Diabetes	☐	☐	Dizziness	☐	☐	Elbow Pain
☐	☐	Epilepsy	☐	☐	Eye/Vision Problems	☐	☐	Fainting	☐	☐	Fatigue
☐	☐	Foot Pain	☐	☐	Genetic Spinal Disorder	☐	☐	Hand Pain	☐	☐	Headaches
☐	☐	Hearing Problems	☐	☐	Hepatitis	☐	☐	High Blood Pressure	☐	☐	Hip Pain
☐	☐	Jaw Pain	☐	☐	Joint Stiffness	☐	☐	Knee Pain	☐	☐	Leg Pain
☐	☐	Low Back Pain	☐	☐	Menstrual Problems	☐	☐	Mid Back Pain	☐	☐	Minor Heart Trouble
☐	☐	Multiple Sclerosis	☐	☐	Neck pain	☐	☐	Neurological Disorder	☐	☐	Pacemaker
☐	☐	Parkinson's Disease	☐	☐	Polio	☐	☐	Prostate Problems	☐	☐	Shoulder Pain
☐	☐	Significant Weight Change	☐	☐	Spinal Cord Injury	☐	☐	Sprain/Strain	☐	☐	Stroke/Heart Attack
☐	☐	Stomach Problems	☐	☐	Tumor	☐	☐	Ulcer/s	☐	☐	Wrist Pain

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PATIENT INFORMATION SHEET

LIST MEDICATIONS / REASON FOR MEDICATION -

_____

_____

_____

PATIENT EMAIL _____

PREFERRED LANGUAGE _____ SMOKING STATUS _____

RACE ETHNICITY _____

CELL PHONE _____

PATIENT SIGNATURE _____ DATE _____

PATIENT COMPLETE

Blood Pressure	Pulse	Height	Weight	Temperature

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PATIENT INFORMATION SHEET

(c) Is required to abide by the terms of this Privacy Notice. [63]

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all your PHI that it maintains. [64]

(e) Will distribute any revised Privacy Notice to you prior to implementation. [65]

(f) Will not retaliate against you for filing a complaint. [66]

EFFECTIVE DATE:

This Notice is in effect as of _____/_____/_____

By signing below, I certify that I have received and reviewed this notice and all of my questions have been answered to my satisfaction in language I can understand.

Additionally I request that my physicians and treatment centers release to Dr. Hargis any medical information or test results needed for his treatment of my person.

PLEASE SIGN

_____ _____

Name of Individual (Printed) Signature of Individual

_____ _____

Signature of Legal Representative (e.g., Attorney-In-Fact, Guardian, Parent if a minor) Relationship

Date Signed _____/_____/_____ Witness _____

LAST PAGE OF PRIVACY STATEMENT AND AUTHORIZATION TO RELEASE PATIENT RECORDS