Jeffrey E. Poplarski, D.C.
Patient Information Sheet

217 Merrick Rd.
Suite 204
Amityville, NY 11701
Tel. (631) 598-7034
Fax (631) 598-7479

PERSONAL **TODAYS DATE**_____

Name:_____ Sex _____
Address_____
City_____ Zip_____ Tel: _____
D.O.B._____ Age_____ Marital Status_____
Social Security # _____
In case of emergency contact: _____
Relationship_____ Tel: _____
Employer_____
Address_____ Tel: _____
Referring Doctor_____ Primary Care Physician_____
e-mail address _____Fax # _____
Referred by: _____

INSURANCE

Name of Insured _____ Sex_____
Address _____
City_____Zip_____Tel_____
Insured DOB _____Insured Social Security_____
Relationship to Patient: self_____ spouse_____ child ___other____
Employer_____
Address_____Tel_____

Primary Insurance

Name _____
Policy#_____
Group#_____
Address_____
_____
Tel #_____

Secondary Insurance

Name_____
Policy#_____
Group#_____
Address_____
_____
Tel#_____

Medicare_____ Workers Comp_____ No Fault _____Private _____Auto_____

Do you have a deductible? _____ $ Amount_____
If yes, have you met your deductible? _____
Do you have a co-payment? _____ $ Amount_____

I hereby authorize payment of medical benefits to Jeffrey E. Poplarksi, D.C, for services rendered by him in person or under his supervision. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits payable for related services. I understand that I am financially responsible for any balance not covered by my insurance. I certify that the information given by me in applying for payment is correct.

Signature:_____ Date: _____

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FOR ALL PATIENTS

1. HAVE YOU EXPERIENCED THIS PROBLEM BEFORE?
2. HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING? ❑ X-RAYS ❑ EMG ❑ CAT SCAN ❑ EKG
3. HAVE YOU SUFFERED FROM ANY OF THE FOLLOWING? CHECK (✔) ALL THAT APPLY:
   ❑ SURGERY ❑ FRACTURES / DISLOCATIONS ❑ SERIOUS DISEASE ❑ PREV. ACCIDENT
   IF YES TO ANY OF THE ABOVE, PLEASE LIST DATES, DOCTORS AND HOSPITALS:

   _____

   _____
4. ARE YOU PRESENTLY TAKING ANY MEDICATION AND / OR DIET SUPPLIMENTS? (IF SO, PLEASE LIST)

   _____

   _____
5. DO YOU PRESENTLT ENGAGE IN ANY OF THE FOLLOWING? ❑ ALCOHOL ❑ CIGARETTES
   ❑ RECREATIONAL DRUGS ❑ DIET PILLS 6. DO YOU EXCERCISE? _____
7. NUMBER OF HOURS OF SLEEP PER DAY _____ 8. SLEEP QUALITY? _____
9. OCCUPATIONAL HAZZARDS _____
10. QUALITY OF DIET? FAST FOOD ____ X/DAY, BALANCED MEALS ____ X/DAY, COFFEE ____CUPS/DAY
    WATER ____ GLASSES/DAY, OTHER FLUIDS ____ GLASSES/DAY, LIST TYPE(S)_____
11. ARE YOU PRESENTLY UNDER STRESS? _____
12. WHAT IS YOUR GOAL FOR THERAPY? _____

WORKER'S COMPENSATION QUESTIONAIRE

1. TYPE OF ACCIDENT: ❑ AUTOMOBILE ❑ ON THE JOB ❑ OTHER _____
2. DATE AND TIME INJURY OCCURED: MONTH ____ DAY ____ YEAR____ TIME____ ❑ AM ❑ PM
3. DID YOU REQUIRE HOSPITALIZATION? _____ ❑ EMERGENCY ROOM or ❑ ADMITTED
   DID YOU SEE A PHYSICIAN? _____ WHO? _____
   DID YOU LOSE TIME FROM WORK? _____ FROM _____ TO _____
   PREVIOUS WORKER'S COMP. INJURIES? _____
4. BRIEFLY DESCRIBE THE DETAILS OF YOUR ACCIDENT: _____

   _____

   _____
5. EXACTLY WHERE DID YOU FEEL PAIN IMMEDIATELY AFTER THE ACCIDENT? _____

   _____

   _____
6. WHAT TYPE OF PROBLEM ARE YOU PRESENTLY HAVING? _____
7. ACCIDENT REPORTED TO EMPLOYER? _____ IF SO, TO WHOM? _____
8. HAVE YOU RECEIVED TREATMENT BY ANY OTHER HEALTH PROFESSIONALS? ____ IF SO LIST:

   _____

   _____

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Underline Any of the Following Problems You Have Had Previously:

Appendicitis	Malaria	Chicken Pox	Alcoholism
Scarlet Fever	Tuberculosis/TB Contact	Diabetes	Venereal Infection
Diphtheria	Whooping Cough	Cancer	Arthritis
Typhoid Fever	Anemia	Heart Disease	Epilepsy
Pneumonia	Measles	Asthma	Mental Disorder
Rheumatic Fever	Mumps	Influenza	Eczema/Psoriasis
Polio	Small Pox	Pleurisy	Metal Implants
HIV / AIDS	Lyme Disease	Hepatitis	Pancreatis
Kidney Disease	Thyroid Disease	Gastric Ulcers	Hernia

Please Underline All of the Following Symptoms You Have Had Previously.

Please Circle All of the Following Symptoms You Have Now.

GENERAL SYMPTOMS
Headache
Weakness
Fever/chills
Heat/cold intolerance
Sweats
Dizziness/Fainting
Osteoporosis
Convulsions
Loss of sleep
Fatigue
Weight change
Numbness or pain in arms, hands or legs
Allergies/hay fever
Head trauma
Neuralgia
Loss of balance
Tremors/Nervousness
Sensory disturbances

E.E.N.T.
Failing Vision
Near or Farsightedness
Cross eyed
Eye pain
Deafness
Earaches
Ear noises/ringing
Ear discharge
Nose bleeds
Nasal obstruction
Sore throat/Hoarseness
Dental problems
Frequent colds
Enlarged thyroid
Tonsillitis
Sinus infection
Nasal Drainage
Enlarged glands
Vertigo
TMJ problems

SKIN
Skin cancer
Skin eruption/Boils
Itching/Dryness
Bruises easily
Varicose veins
Allergy/hives
Phlebitis
Change in moles

RESPIRATORY
Chronic cough
Spitting up phlegm
Spitting up blood
Difficult breathing/Wheezing

CARDIO-VASCULAR
Rapid or Slow heart beat
High or Low blood pressure
Pain over heart
Previous heart attack
Hardening of arteries
Swelling of ankles
Poor circulation
Stroke
Pacemaker
Chest pain

MUSCLE & JOINT SYMPTOMS
Stiff neck
Backache
Swollen/painful joints
Painful tail bone
Foot trouble
Pain between shoulders
Spinal curvature
Faulty posture
Muscle cramps or fatigue
Difficulty walking
Paralysis or muscle weakness
Upper/lower extremity problems
Congenital spinal defects
Spinal disc degeneration
Uneven hips/legs

GENITOURINARY SYMPTOMS
Frequent urination day or night
Painful urination
Blood in urine
Pus/discharge
Kidney infection/stones
Bed wetting
Bladder Incontinence
Urinary tract infection

GASTROINTESTINAL SYMPTOMS
Indigestion/heartburn
Belching or gas
Nausea/vomiting
Difficulty swallowing
Vomiting of blood
Pain over abdomen
Distention of abdomen
Constipation
Blood in stools
Diarrhea
Colon trouble/Colitis
Hemorrhoids (piles)
Intestinal worms
Liver trouble/Jaundice
Gall bladder trouble

FOR MEN ONLY
Prostate trouble
Testicular mass/pain

FOR WOMEN ONLY
Painful menstrul periods
Excessive flow
Irregular cycle
Cramps or backaches
Previous miscarriage
Vaginal discharge
Breast lump/pain
Menopausal symptoms
Pelvic pain
Pelvic mass/cyst

Are you pregnant? ❑ Yes ❑ No
Date of last period _____

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PATIENT HISTORY FORM

1. CHIEF COMPLAINT or PAIN: _____

_____

2. How long have you had this problem? _____ Do you know how the problem began? _____

Traumatic (fall, external blow, etc.)
Non-traumatic- **Sudden** probably an **acute** process, **Gradual** onset probably a chronic process.

_____

_____

3. What makes the problem worse? _____

_____

4. What makes the problem better? _____

_____

5. How would you describe your pain? Check (✔) **all** that apply:

❑ Superficial	or	❑ Deep	❑ Numbness	❑ Hot
❑ Local	or	❑ General	❑ Throbbing	❑ Cold
❑ Stabbing		❑ Tingling	❑ Sharp	❑ "Pins & Needles"
❑ Boring		❑ Dull Ache	❑ Burning	❑ _____

6. What is the exact location of the problem? _____

7. Does the pain travel anywhere? _____

8. Is the problem ❑ Intermittent or ❑ Constant? How long does it last? _____

Does it occur mostly during the ❑ day or ❑ night? _____

9. **ACTIVITIES OF DAILY LIVING:**
Check (✔) **all** the activities you are **unable** to do or have **difficulty** with because of this problem.

❑ Sitting	❑ Shopping	❑ Moving Arms	❑ Transfer to/from shower
❑ Standing	❑ Lifting	❑ Moving legs	❑ Walking at home
❑ Bathing	❑ Carrying	❑ Lying/sleeping	❑ Walking in community
❑ Driving	❑ Reaching	❑ Turning over	❑ Recreational activities
❑ Dressing	❑ Typing	❑ Moving to/from bed	❑ Using stairs
❑ Grooming	❑ Kneeling	❑ Going to the bathroom	❑ Using appliances/phone
❑ Bending	❑ Pulling	❑ Cough/ sneeze	❑ Managing children
❑ Twisting	❑ Pushing	❑ Moving to/from chair	❑ Household chores

10. List WORK RELATED DUTIES you have difficulty performing: _____

_____

_____