

VILLAGE SQUARE



HEALTH & WELLNESS

7 Village Square • Glen Cove, NY 11542

Tel: 516-759-2032 • Fax: 516-759-2117

Lifenrg@verizon.net

Name _____ Email Address _____
Home Phone _____ Work Phone _____
Address _____ City _____
State, Zip _____ SS #: _____
Date of Birth _____ Sex M F Referred By _____
Employers Name _____ Occupation _____
(If Minor, Parent's Employer)
Employer's Address _____
Spouse's Name _____ Spouse's Employer _____
Which of the following will you be using?
 Major Medical Insurance Medicare Worker's Comp Auto Accident Other: _____
How will you pay today? Cash Check Credit Card (MC / Visa)
Name of Insurance Co _____ Are You Policy Holder? Yes No
* If not you, Who? _____ Policy Holder's SS # _____
Policy Holders Date of Birth _____ Policy Holder's Employer _____

1. Major Complaint _____
2. Please describe your pain (You may check one or more answers)
 Stabbing Sharp Aches Dull Weakness Throbbing Numb Shooting Tingling
3. How often are your complaints present?
Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Intermittent (25% or less)
4. How painful is your pain/condition? Circle one: No Pain..1 2 3 4 5 6 7 8 9 10 ... Unbearable pain
5. When did your problem begin? Specific date if possible _____
6. Since your pain began, is the pain: Increasing Decreasing Not Changing
7. How did your problem begin: (Please check all that apply)
 Immediately after incident Multiple incidents Gradually over time No specific reason
8. What treatment have you already received? Surgery Physical Therapy Drugs Other: _____
9. What makes you feel better? Lying Down Walking Standing Sitting Movement Inactivity
10. What makes you feel worse? Lying Down Walking Standing Sitting Movement Inactivity
11. How would you grade your general stress level? Minimal Stress Moderate Stress Greatly Stressed

Please turn over and complete side #2



If you are presently troubled by a particular symptom, check that symptom in the Present Column. If you have ever had a listed symptom in the past, please check that symptom in the Past Column.

Please check any of the following that apply to you:

Never	Past	Present		Never	Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Upper Arm or Elbow Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hand or Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation / Irregular Bowel
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hip or Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn / Indigestion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lower Leg or Knee Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills Used
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ankle or Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaw or TMJ Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness / Blurred Vision
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swelling / Stiffness of Joint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Pain

Listed below are common diseases and disorders. Please indicate whether you have had a particular disorder in the past or are presently troubled by a listed disorder.

Never	Past	Present		Never	Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Stones*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colitis*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel Syndrome*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anorexia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____				

Are you interested in receiving information about a natural approach to:

Anti Aging	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> I Don't Know
Detoxification Programs for Colon, Liver, Gall Bladder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> I Don't Know
Chelation Therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> I Don't Know

I attest that the above is true and correct to the best of my knowledge and authorize treatment.

_____ Date

I hereby authorize the attending Doctor to release any information concerning my examination and/or treatment

_____ Date

I hereby assign payment directly to this office for professional services rendered and I shall be responsible for any unpaid balance to the Doctor

_____ Date