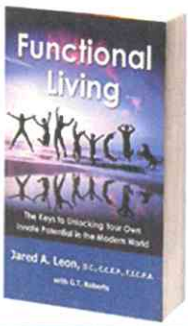
LEON Chiropractic
Dr. Jared Leon
213 Hallock Rd Suite 4B
Stony Brook, NY 11790
(631) 689-1000



Name_____

Address_____

City/State/Zip _____

Phone #'s (home) _____(cell) _____

E-mail address_____

Birthdate_____Age_____

Occupation_____Employer_____

Marital status _____Spouse's name_____

Do you have any children?_____If yes, names and ages please_____

_____

Favorite hobbies or interests _____

Emergency contact: Name_____

Relationship_____Phone #(s)_____

What Brings You Here?

Is this appointment for you or another family member? _____

Has the patient ever had chiropractic care before?_____

Was the patient pleased with the care and what were the results?_____

_____

How did you find our office?_____

Is this appointment related to any of the following?

- ○ Work
- ○ Sports
- ○ Auto
- ○ Personal injury
- ○ Other: _____

When did the incident occur? _____

Please list any drugs or medications you are taking _____

_____

Please list any vitamins/herbs/homeopathics/other you are taking _____

_____

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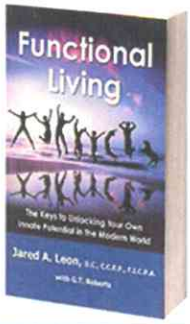

Pregnancy

Is the patient pregnant?_____If yes, how many weeks?_____

Muscular Skeletal

Does the patient have pain in any of the following? Please check all that applies to the patient.

- o Neck
- o Sternum
- o Shoulder Right/Left
- o Arm Right/Left
- o Elbow Right/Left
- o Wrist Right/Left
- o Upper Back
- o Lower Back
- o Hip/Sciatica Right/Left
- o Knee Right/Left
- o Ankle Right/Left
- o Foot Right/left

Does the patient suffer or have ever been diagnosed with any of the following? Please check all that applies to the patient.

- o Acid reflex
- o Adrenal Fatigue
- o Allergies
- o Asthma
- o Chronic cough
- o Chronic infections
- o Colitis
- o Constipation
- o Crohn's disease
- o Epstein-Barr Virus
- o Irritable Bowel
- o Leaky Gut
- o Lyme's disease
- o Numbness/Tingling
  Body Part:_____
  _____
- o Sexual Dysfunction
- o Sleep disorders

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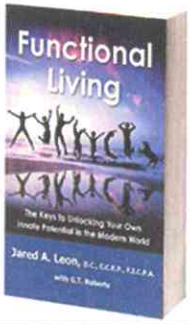

Neurological

Does the patient suffer from any of the following? Please check all that applies.

- ADD/ADHD
- Adrenal
- Alzheimer
- Anxiety
- Brain Fog
- Clumsiness
- Deadly thoughts
- Dementia
- Depression
- Dizzy
- Doubt
- Extremely judgmental
- Falling often
- Fatigue
- Fear
- Headaches
- Hearing loss
- High blood pressure
- High cholesterol
- Infertility sexual problems
- Learning disabilities
- Memory loss
- Migraines
- Moderate/severe stomach pain
- Motion sickness
- Multiple Sclerosis
- Organizational skills
- Parkinson
- Shaking/Tremors
- Shape discernment
- Stuttering
- Thyroid
- Tinnitus
- Trouble speaking
- Vertigo
- Worry

Does the patient use any of the following?

- Alcohol
- Cigarettes
- Coffee
- Drugs
- Fat Free foods or drinks
- Soda
- Sweeteners
- Sugar Free foods or drinks

On a scale from 1 to 10 with 1 being poor and 10 being excellent, please rate the following:

How positive are the patient's daily thoughts ____
How does the patient rate his/her daily nutrition ____
How does the patient rate his/her sleep____ How many hours sleep does he/she average daily _____
How does the patient rate his/her global lifestyle choices ____
How often does the patient engage in cardio exercise? _____
How often does the patient engage in strength exercise? _____
How often does the patient engage in stretching/yoga? _____
How often does the patient read? _____

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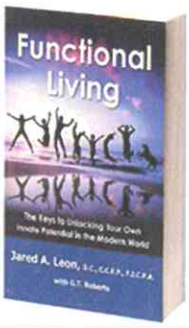

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the potential risks involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides Dr. Leon with your permission to perform reasonable and necessary functional chiropractic and/or functional neurological testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with Dr. Leon about the purpose, potential risks and benefits of all functional chiropractic and functional neurological treatment. If you have any concerns regarding any test or treatment recommend by Dr. Leon, we encourage you to ask questions. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Consent to Treatment:

Signature:_____ **Date:**_____

I only consent that I am here for muscular skeletal and choose to bypass a neurological exam.

Signature:_____ **Date:**_____

LEON CHIROPRACTIC
213 Hallock Road, Suite 4B
Stony Brook, NY 11790
631-689-1000

Notice of Privacy for Patient's Protected Health Information

This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office abides by the terms described in this policy.

This office uses and discloses your protected health care information for the following reasons:

- To share with other treating health care providers regarding your health care.
- To submit to insurance companies or Worker's Compensation to verify that treatment has been rendered.
- To determine patient's benefits in a health care plan.
- To release information required by State or Federal Public Health Law.
- To assist in overcoming a language barrier when caring for a patient.
- To business associates, providing written assurances for your privacy have been attained.
- Emergency situations.
- Abuse, neglect, or domestic violence.
- Appointment reminders to household members and/or answering machines.
- Sign-in logs may be disclosed to verify office visits.
- To send out birthday cards and newsletters.

Any other uses or disclosures will only be made with your specific written prior authorizations.

You have the right to:

- Revoke authorization, in writing, at any time by specifying what you want restricted and to whom.
- Inspect, copy and amend your protected health information and amend it as allowed by law.
- Obtain an accounting of disclosures of your protected health information.
- Render a complaint to our privacy officer.

This office reserves the right to change the terms of this notice and make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received and review this notice with full understanding.

_____	_____	_____
Name of Patient	Signature of Patient/Legal Representative	Date