209-35 Northern Blvd. Suite 209 Bayside, N.Y. 11361
TEL/SMS: 718-577-8933 FAX: 718-806-9067
E-Mail: nycorechiro@gmail.com
WWW.NYCORECHIRO.COM

Please fill out forms completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance.

Patient Data

First Name: __________________ Middle Initial: ________ Last Name: __________________ Date of Birth: ______/______/______

Address: ____City: _______________________ Zip Code: ________________

Home #: (______) ________-___________ Cell #: (______) ________-___________ Social Security #: ________-______-__________

Email: ____ Height: _______________ Weight: ______________

Have you ever received Chiropractic Care? Yes / No If Yes, why did you seek chiropractic treatment?

____

How did you hear about our office? ____

Emergency Contact

Contact Name: ____ Contact Number: (_______)__________-___________

Relationship to the Patient: ____

Employer Data:

Employer: ____ Occupation: _________________________

Insurance Information (FILL OUT ONLY IF THE PATIENT IS **NOT** THE PRIMARY INSURED)

Insurance Company: _________________________________ Phone: (_____)______-_______
Name of insured person:_____________________ Their date of birth: ____________________
Relationship of insured to patient: Self Spouse Child Other ______________

LIST RESTRICTED ACTIVITY **CURRENT ACTIVITY LEVEL** **USUAL ACTIVITY LEVEL**

______________________________: ____
______________________________: ____
______________________________: ____
______________________________: ____

Identify any other injury(s) to your spine, minor or major, that the doctor should know about?

____

____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office:

(1) Primary:____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your complaints by ***circling the number***:

Primary or chief complaint is: (No pain) <- 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 -> (Worst pain possible)

When did the problem(s) begin?_________________When is the problem at its worst? ☐ AM ☐PM ☐Mid-day ☐Late PM

Is symptom getting: (Better) (Not Changing) (Worse)

How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

How did the injury happen?____

Is this due to an accident: ☐Yes ☐No **Date of Accident**:______________________

Does the complaint/pain radiate or travel to any areas of your body? If so, where? ____________________________

Does anything aggravate the complaint?____

Does anything make relieve the complaint?____

(2) Secondary:____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your complaints by ***circling the number***:

Secondary complaint is: (No pain) <- 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 -> (Worst pain possible)

When did the problem(s) begin?_________________When is the problem at its worst? ☐ AM ☐PM ☐Mid-day ☐Late PM

Is symptom getting: (Better) (Not Changing) (Worse)

How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

How did the injury happen?____

Is this due to an accident: ☐Yes ☐No **Date of Accident**:______________________

Does the complaint/pain radiate or travel to any areas of your body? If so, where? ____________________________

Does anything aggravate the complaint?____

Does anything make relieve the complaint?____

(3) Third:____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your complaints by ***circling the number***:

Primary or chief complaint is: (No pain) <- 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 -> (Worst pain possible)

When did the problem(s) begin?_________________When is the problem at its worst? ☐ AM ☐PM ☐Mid-day ☐Late PM

Is symptom getting: (Better) (Not Changing) (Worse)

How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

How did the injury happen?____

Is this due to an accident: ☐Yes ☐No **Date of Accident**:______________________

Does the complaint/pain radiate or travel to any areas of your body? If so, where? ____________________________

Does anything aggravate the complaint?____

Does anything make relieve the complaint?____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ☐ Yes ☐No If **yes** how many times?____________
When was the last episode?_______________________________________ How did the injury happen? ____________________

Other forms of treatment tried: ☐No ☐Yes If **yes**, please state what **type** of treatment: ____________________________, and

who provided it: _______________________ How long ago?_________ What were the results: ☐Favorable ☐Unfavorable → please explain: ____
Any Xray, MRI, CT before? ______________________________ When? ____
If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the **Past**, **C** for **Currently** have, or **N** for **Never** have had:
______Broken Bone ______Dislocations ______Tumors ______Rheumatoid Arthritis ______Fracture ______Disability ______Cancer
______Heart Attack ______Osteo Arthritis ______Diabetes ______Cerebral Vascular _____Other serious conditions:_____________

Please identify ALL PAST and any **Current** conditions you feel may be contributing to your present problem:

Injuries **(1)** →	
(2) →	
Childhood Disease →	
Adult Disease →	
Allergies →	
Current Medications →	
Current Supplement →	

Surgeries: **(CHECK all that applies to you)**

☐ Appendectomy	☐ Cardiovascular Procedures
☐ Cervical Spine	☐ Hysterectomy
☐ Joint Replacement	☐ Prostate
☐ Lumbar Spine	☐ Gall Bladder
☐ Brain	☐ Shoulder
☐ Thoracic Spine	☐ Knee
☐ Carpal Tunnel	☐ Gastro-intestinal
☐ Urogenital	☐ Hernia
☐ Other: (Please specify)	☐ Other: (Please Specify)

Social History

1. **Smoking:** ☐Cigar ☐Pipe ☐Cigarettes →How Often ☐Daily ☐Weekends ☐Occasionally ☐Never
2. **Alcoholic Beverage**: Consumption occurs → ☐Daily ☐Weekends ☐Occasionally ☐Never
3. **Recreational Drug use:** → ☐Daily ☐Weekends ☐Occasionally ☐Never

In general, your overall health right now is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor