CNY Family Chiropractic 102 West Seneca St

New Patient Intake Form Suit 205

 Manlius, NY 13104

 (315) 692-2078

Date: \_\_\_/\_\_\_\_/\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_\_ Sex: M / F

Cell Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: M / S / D / W Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Children: Y / N Ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about the office: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Hobbies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise: Y / N How often: \_\_\_\_\_\_\_\_\_\_\_ What Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diet: Healthy / Ave / Poor Vitamins / Supplements: Y / N

Alcohol: Never / Rare / Moderate / Daily Smoker: Y / N / Former

**Treatment and Finances:** First and foremost the priority in this office is to provide the highest quality of care to all patients. As a courtesy our office will provide each patient with a detailed invoice that can be submitted to insurance for reimbursement directly **from your insurance company to you**. Please be sure to let us know if you would like an invoice. Though we are happy to provide you with this, it is our policy to collect payment in the office at the time of service.

[ ]  I understand that payment is due at the time of service and upon request this office will provide me with a detailed invoice that may be submitted to my insurance company.

[ ]  **I have questions** about this policy or have other financial related concerns and would like to have a conversation about someone in the office about this.

**Patient Health Profile:**

Primary Complaint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did this start: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is it getting worse: Yes / No

What percentage (%) of the time are you in Pain: ­\_\_\_\_\_\_\_\_\_\_ Is it Constant: Yes / No

Rate the severity of your pain on a scale from 1 (least) to 10 (Severe):

 Current Today \_\_\_\_\_\_ Worst Ever \_\_\_\_\_\_ Average \_\_\_\_\_\_

Type of pain: (Circle all that apply)

 Aching / Dull / Throbbing / Sharp / Shooting / Burning / Tingling

 Stiff / Cramping / Pressure / Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General History**

Please tell us what medications and/or supplements you currently take:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any traumatic injuries or car accidents: List all surgeries/hospitalizations and dates

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Concerns Checklist – Please indicate on the list below a “C” for current or “P” for past.**

\_\_\_ Anemia

\_\_\_ Arthritis

\_\_\_ Asthma

\_\_\_ Back Pain

\_\_\_ Bleeding Disorders

\_\_\_ Cancer

\_\_\_ Cold Hands / Feet

\_\_\_ Depression / Anxiety

\_\_\_ Diabetes

\_\_\_ Dizziness

\_\_\_ Epilepsy

\_\_\_ Fainting

\_\_\_ Fatigue

\_\_\_ Fractures

\_\_\_ Headaches

\_\_\_ Heart Disease

\_\_\_ Hernia

\_\_\_ Herniated Disc

\_\_\_ High Blood Pressure

\_\_\_ High Cholesterol

\_\_\_ Loss of Balance

\_\_\_ Menstrual Pain

\_\_\_ Multiple Sclerosis

\_\_\_ Neck Pain / Stiffness

\_\_\_ Numbness in Arms

\_\_\_ Numbness

 Hand/Finger

\_\_\_ Numbness Legs / Toes

\_\_\_ Osteopenia /

 Osteoporosis

\_\_\_ Pinched Nerve

\_\_\_ Rheumatoid Arthritis

\_\_\_Stroke

\_\_\_ Ulcer

\_\_\_ UTI

\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Health History**

Please mark below any conditions that apply to your ***FAMILY*** health history.

\_\_\_ Heart Disease \_\_\_ Seizures \_\_\_ Kidney Disease

 \_\_\_ Ulcer / Stomach Problems \_\_\_ Back Problems \_\_\_ Arthritis

\_\_\_ Headaches \_\_\_ Cancer \_\_\_ Osteoporosis \_\_\_ Diabetes

**Health Goals**

Please take a moment to fill out the chart below so that we may understand your goals for overall health and wellbeing.

Please list your Health and Wellness goals in the spaces provided

|  |  |  |
| --- | --- | --- |
| Physical Goals | Nutrition Goals | Stress / Emotional Goals |
|  |  |  |
|  |  |  |

**How can we help you?**

It is our desire that all patients get the BEST possible result so that they may live a LONGER, HAPPIER and HEALTHIER LIFE as a result of our care. With that being said, it is more important to know what your wants and desires are moving forward.

Please Mark Appropriately:

\_\_\_\_ I only wish to get out of pain \_\_\_\_ I want to get out of pain AND fix the underlying problem

\_\_\_\_ I am interested in fixing the problem and maintaining it moving forward

At CNY Family Chiropractic we are always here to answer any questions you have about your heath or care in our office. If you have any questions or concerns, please specify below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I consent to a complete Chiropractic examination and any other diagnostic testing that the doctor deems necessary. I understand the doctor will do his best to explain as much as possible about procedures pertaining to testing and care and that if I have questions at any time I will ask.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_