

EMPIRE CHIROPRACTIC, P.C.

10 East 39th Street Ste. 914

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WELCOME TO OUR OFFICE

Why did you choose our office?

For our time together to be a "true win" for you, what do you want to take place over the course of your care here?

How long do you feel this will take?

Please list any self destructive lifestyle habits (e.g. smoking, lack of exercise, addictions etc.)

What is your present level of commitment to change the underlying cause of problem(s) which relate to your lifestyle? (Rate from 1-10, with 10 being 100% committed).

What might stop you from following the therapeutic protocols that we may prescribe for you?

Referring Doctor: name, address and phone number:

Empire Chiropractic, P.C.

Patient Information

Name: _____ Social Security Number: _____
Address: _____ City _____ State _____ Zip _____
Home Phone: _____ Work Phone: _____ Cell: _____
Employer: _____ Address: _____
Occupation: _____ Age: _____ Date of Birth: _____
Marital Status: M S W D Referred by: _____ E-Mail _____
Emergency Contact Name: _____ Phone: _____
Guardian's/Partner/Spouse's Name: _____ Phone: _____
Name of Health Insurance Company: _____ Policy Number: _____
Name of Policy holder _____

General Health Information

1. What is your major complaint? _____
2. How long have you had this condition? _____
3. Have you been in an auto accident? ___ Past Year ___ Past 5 years ___ Over 5 years ___ Never
4. Is this condition due to a job-related injury? _____
5. Have you had similar conditions in the past? _____
6. What activities aggravate your condition? _____
7. What activities relieve your condition? _____
8. Describe your pain condition (Pls. also refer to Pain Diagram):
___ Constant ___ Intermittent ___ Getting better ___ Getting worse
9. What treatment/medication have you already received for this condition or any other conditions? _____

10. Have you ever suffered from?

- Dizziness Backaches Heart Trouble Diabetes Arthritis
 Headaches Asthma Digestive Disorders Neuritis Nervousness
 Sinus Trouble Neck Pain Psychological Problems

Describe any other medical conditions: _____

11. List surgical operations and years: _____

12. Have you ever had: Cancer Pancreatitis Ulcer

13. Women: Do you currently have Abnormal menses Endometriosis
 Ovarian Disease Uterine fibroids

14. Men: Do you currently have prostate disease? _____

15. Have you recently experienced any Fevers Chills
 Unexplained weight loss
 Change in bowel or bladder habits

16. Drugs/Supplements you now take: Nerve pills Painkillers Muscle Relaxers
 "Pep" pills Tranquilizers Insulin
 Birth Control Pills Hormones
Others: _____

17. List any allergies: _____

18. Are you presently pregnant/wearing a demand-type pacemaker? _____

19. Age of mattress: _____ Comfortable Uncomfortable

20. Are you wearing: Heel lifts Sole lifts Inner Sole Arch Supports

ASSIGNMENT: I request that payment of authorized insurance benefits be made on my behalf to Empire Chiropractic, P.C. for any services furnished by the healthcare providers. I authorize any holder of medical information about me to release to the insurance company and its agents any information needed to determine these benefits payable for related services. I understand that this is an out of network provider and that I am responsible for my co-insurance and deductible. I will endorse any checks forwarded to me as payment for the services when such is the case. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

(Date)

(Signature of Patient/Guardian)

PAIN DRAWING

Date _____ Name _____

Draw location of your pain on body outlines and mark how bad it is on path line at bottom of page.

Ache
MMM
M

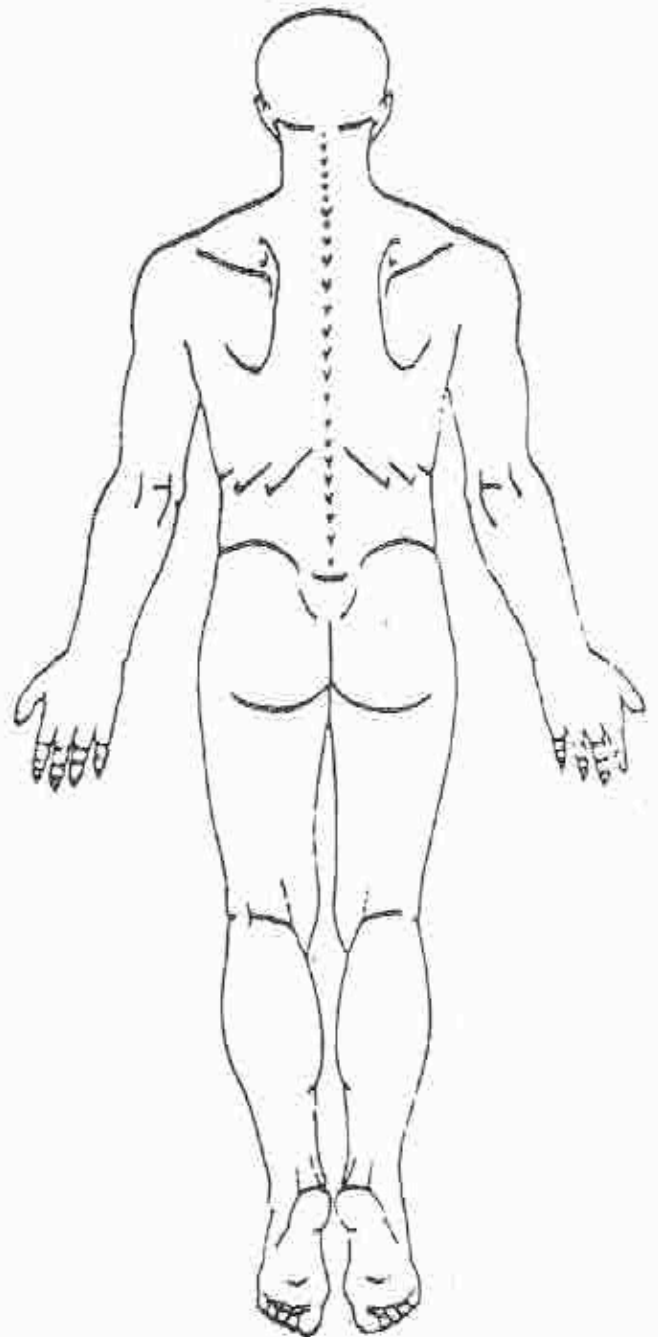
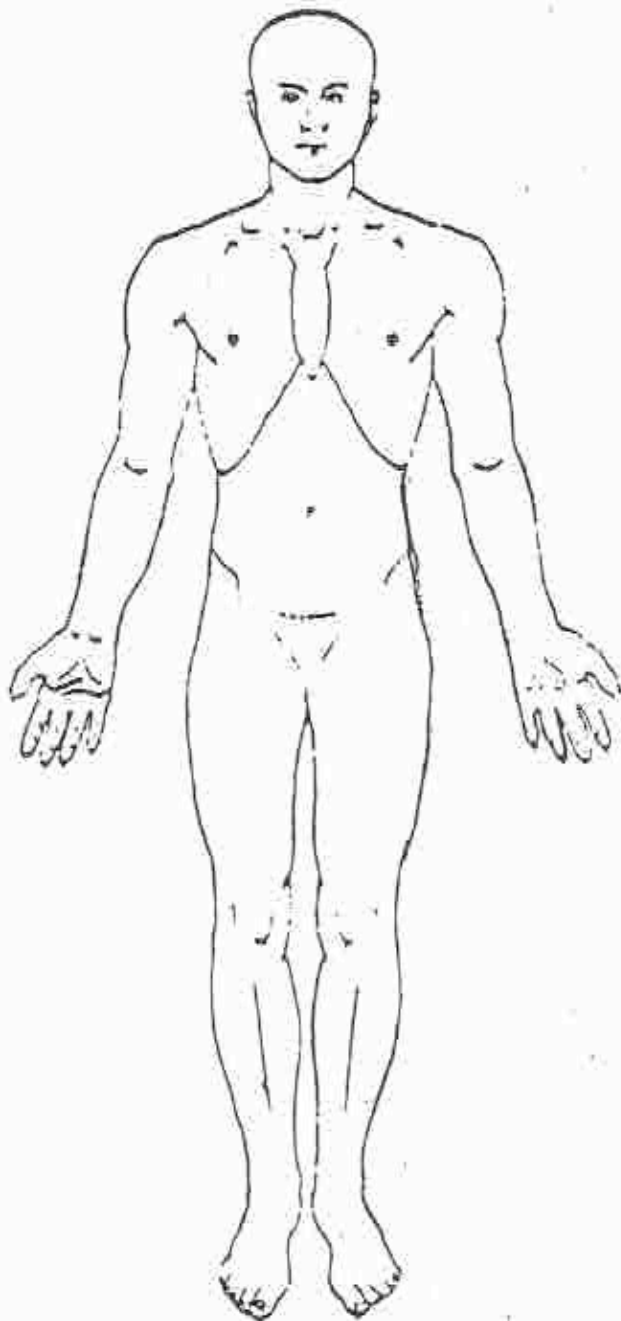
Burning
=====
=====

Numbness
OOOOO
OO

Pin and
Needles
.....

Stabbing
/////

Other
XXXXX
XXX



----- Worst possible pain.