EMPIRE CHIROPRACTIC, P.C.
207 Wanamaker Ln
Nyack, N.Y. 10960
Phone: (212) 563-2966
Fax: (212) 563-3749

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.

_____ _____

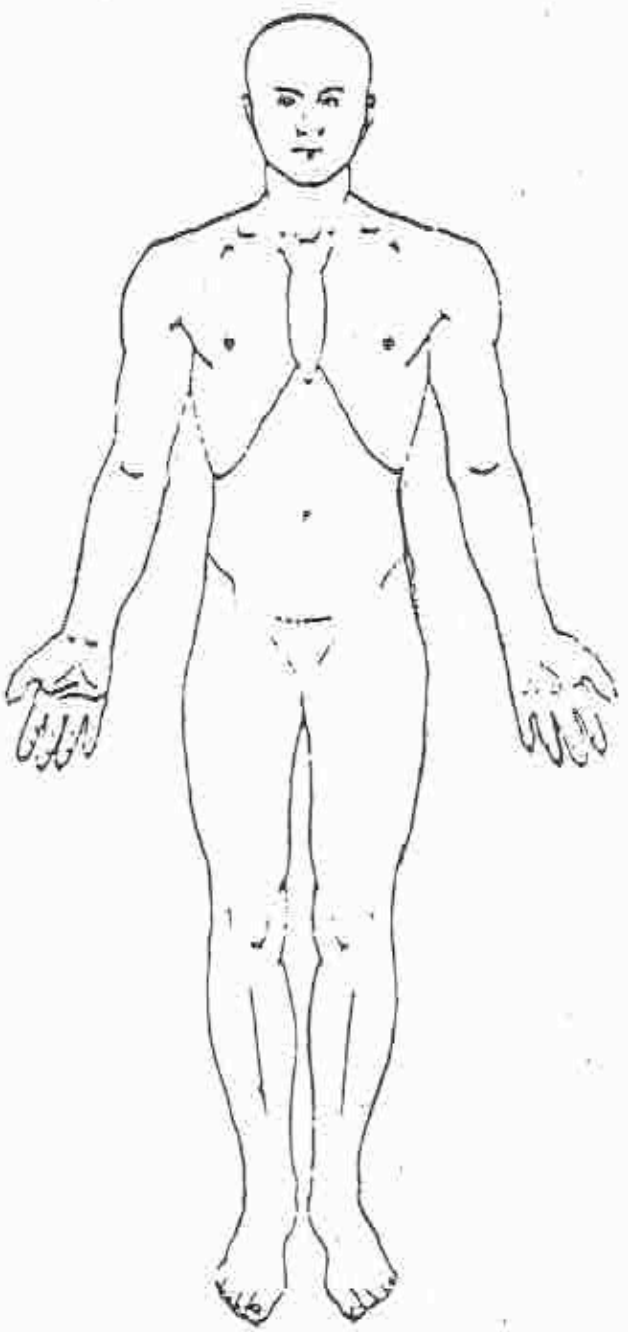
(Date) (Signature of Patient/Guardian)

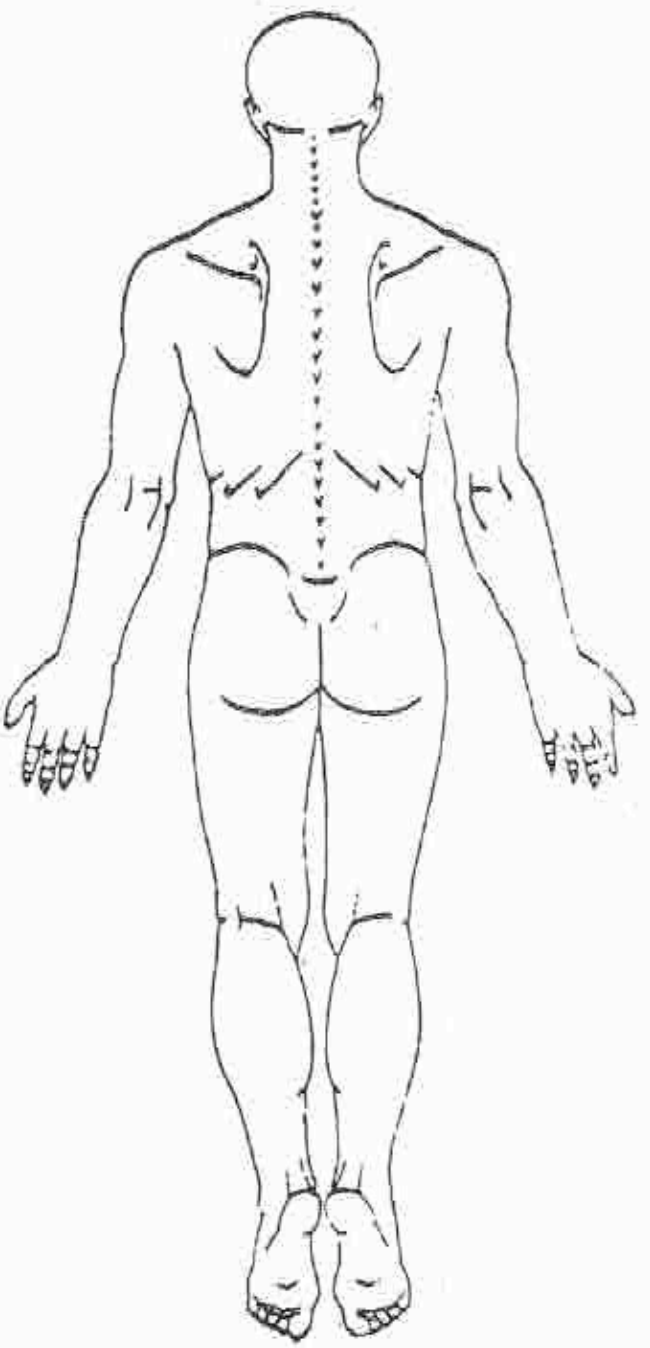
PAIN DRAWING

Date_____ Name_____

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

Ache	Burning	Numbness	Pin and Needles	Stabbing	Other
MMM	= = = =	0 0 0 0 0	. . . . .	/////	X X X X X
M	= = = =	0 0			X X X





_____Worst possible pain