

## Patient Contact Information

Today's Date: \_\_\_\_\_

First Name: \_\_\_\_\_  
 Middle Init: \_\_\_\_\_  
 Last Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State, Zip: \_\_\_\_\_  
 Home Phone: (\_\_\_\_) \_\_\_\_\_  
 Work Phone: (\_\_\_\_) \_\_\_\_\_  
 Cell Phone: (\_\_\_\_) \_\_\_\_\_  
 Children: \_\_\_\_\_  
 Email: \_\_\_\_\_  
This address will not be shared, sold, or distributed to anyone, but may be used to let you know about upcoming events or specials.  
 Primary Doctor: \_\_\_\_\_  
 Primary Phone: \_\_\_\_\_

Sex:  M  F  
 Marital:  Married  Single  Divorced  Separated  
 Partnered  Widowed  Minor  
 Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_  
 Soc. Sec: \_\_\_\_\_  
 Who should we thank for referring you to our office?  
 \_\_\_\_\_  
 Work Status:  Full Time  Part Time  Unemployed  
 Student  Other  
 Employer: \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_  
 Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

## Financial - Insurance Information

Who is Responsible for this account? Self:  Yes ( No Parent/Guardian): Relationship: \_\_\_\_\_  
 Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
 Subscriber's name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

**Assignment & Release of Benefits:** I certify that I, and/or my dependants, have insurance coverage with the above-named insurance company, and assign directly to Dr Bruce J. Cherlow DC PA all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I authorize my signature on all insurance submissions. The above named Doctors may use my health care information and may disclose it to the above named insurance company, and their agents, to determine benefits or benefits payable for related services, and obtain payment for services rendered. This consent will end one year from when my current treatment plan is over, or one year after my last date of service.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Current Patient Condition

Are You Here For Wellness?  Yes  No  
 Are you here to Resolve:  
 New Pain  Chronic Pain  New Injury  Old Injury  
 Are you in pain right now?  Yes  No  
 Rate your pain with the following scale (circle the number)  
 At It's Worst: Discomfort 1 2 3 4 5 6 7 8 9 10 Intense  
 Right Now: Discomfort 1 2 3 4 5 6 7 8 9 10 Intense  
 Please list the symptoms / pains you are seeking help with:

1. \_\_\_\_\_ 3. \_\_\_\_\_  
 2. \_\_\_\_\_ 4. \_\_\_\_\_

**Describe your Condition / Symptoms:**

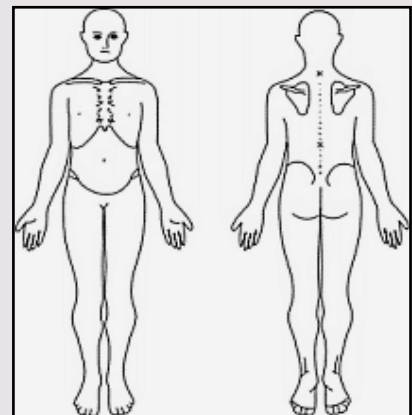
Aching  Stabbing  Shooting  Burning  Stiff  
 Tingling  Cramping  Throbbing  Tight  Other

When did your symptom(s) first appear? \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Has this or something similar happened in the past?  
 Yes  No Explain: \_\_\_\_\_

Is your condition getting worse?  Yes  No  
 Is your condition:  Constant  Comes and goes  
 Worse in:  AM  PM  All Day  At Night

This condition interferes with:  Work  Sleep  Daily Routine  
 What is your condition keeping you from doing that you enjoy?  
 \_\_\_\_\_

**Using the body charts below, please mark where you feel your symptoms.**



**If due to an injury, please fill out this box**

Did your injury occur during:  Auto Accident  
 Work  Sports / Play  Routine / Household  
 Other: \_\_\_\_\_  
 When did your injury occur? \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Where did your injury occur? \_\_\_\_\_  
 Explain: \_\_\_\_\_  
 \_\_\_\_\_

# Patient Health History

Have you ever been to a chiropractor before? Yes No Who? \_\_\_\_\_ When? \_\_\_\_\_  
For this / similar condition? Yes No Other? \_\_\_\_\_

Have you seen any other medical professionals for this condition? MD Orthopedist Physical Therapist  
What were the results? \_\_\_\_\_

Are you taking any of the following medications? Over the counter Pain killers (Aspirin, Tylenol, Motrin...)  
Prescription Pain killers Muscle Relaxers Blood Thinners Tranquilizers Insulin Birth Control  
Please list all Medications Currently Taking: \_\_\_\_\_

Have you had any recent diagnostic tests performed for this condition?  
X-rays MRI CT Scan Blood Work Urinalysis Physical Exam

## **Do you have, or have had any of the following diseases, medical conditions or procedures?**

- |   |   |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Attack / Stroke        | <input type="checkbox"/> Yes <input type="checkbox"/> No Chicken Pox                      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No High/ Low Blood Pressure     | <input type="checkbox"/> Yes <input type="checkbox"/> No Osteo-Arthritis                  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart/ Surgery               | <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatoid Arthritis             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Murmur                 | <input type="checkbox"/> Yes <input type="checkbox"/> No Fractures _____                  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker                    | <input type="checkbox"/> Yes <input type="checkbox"/> No Gout                             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Mitral Valve Prolapse        | <input type="checkbox"/> Yes <input type="checkbox"/> No Herniated disc _____             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Congenital Heart Defect      | <input type="checkbox"/> Yes <input type="checkbox"/> No Polio                            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty Breathing         | <input type="checkbox"/> Yes <input type="checkbox"/> No Prostate Problems                |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema/ Asthma            | <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Problems                 |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Alcohol/ Drug Abuse          | <input type="checkbox"/> Yes <input type="checkbox"/> No Hormone imbalances               |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer _____                 | <input type="checkbox"/> Yes <input type="checkbox"/> No Tumors / Growths                 |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Psychiatric Disorders        | <input type="checkbox"/> Yes <input type="checkbox"/> No Vaginal Infections               |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Fainting/ Seizures/ Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No Bladder Infections               |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Venereal Disease             | <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent Neck Pain               |
| <input type="checkbox"/> Yes <input type="checkbox"/> No HIV / AIDS                   | <input type="checkbox"/> Yes <input type="checkbox"/> No Lower Back Problems              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever              | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis                     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Problems              | <input type="checkbox"/> Yes <input type="checkbox"/> No Sinus Problems                   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease                | <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia/ Diabetes                 |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis                    | <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Bones/ Joints         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Headaches                    | <input type="checkbox"/> Yes <input type="checkbox"/> No Implants / Plastic Surgery _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Migraine Headaches           | <input type="checkbox"/> Other _____  |

List any past serious accidents with dates: \_\_\_\_\_

List All fractures and dates: \_\_\_\_\_

List All Surgeries and dates: \_\_\_\_\_

Do you take Supplements or Vitamins? Yes No Which ones: \_\_\_\_\_

Do you exercise? Yes No \_\_\_\_\_ hours per week Cardio: Yes No Weights: Yes No

Are you wearing: Orthotics: Yes No Shoe lifts: Yes No Arch supports: Yes No

Do you smoke? Yes No Packs/Day \_\_\_\_\_ How Long? \_\_\_\_\_

**For Women:** Are you pregnant? Yes No How many weeks? \_\_\_\_\_ Are you nursing? Yes No

## Policies & Consent

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made. I authorize and give consent to the Doctors & staff to perform any necessary services, during diagnosis and treatment. I understand the above written information on this form, and guarantee this form was completed correctly to the best of my knowledge and I understand it is my responsibility to inform this office of any changes to the information I have provided.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Adult patient      Parent or Guardian      Spouse