



853 Broadway, Suite 1601, New York, NY 10003 (212) 777-3301

Last: _____ First: _____ MI: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____

Work #: _____ Ext.: _____

Date of Birth: _____ Age _____ SS# _____

Email: _____

____ M ____ F _____ Single _____ Married _____ Partnered

Emergency Contact: _____ Tel. #: _____

Primary Care Physician: _____ Tel. #: _____

Address: _____

City: _____ State: _____ Zip: _____

Would you like a report detailing your treatment sent to your primary care physician? Yes No

Employer: _____ Occupation: _____

Referred by: _____

Symptoms

Reason for visit? _____

When did you first notice the symptoms? _____

How did the symptoms begin? _____

Type of pain you are feeling: ___ Numbness ___ Aching ___ Shooting ___ Burning ___ Tingling ___ Throbbing ___ Stiffness ___ Swelling ___ Cramps ___ Sharp ___ Dull ___ Other _____

Rate the severity of your pain (1-Mild to 10-Severe): 1 2 3 4 5 6 7 8 9 10

Is this condition getting progressively worse? ___ Yes ___ No

Is the pain constant ___ or does it come and go ___?

Do you have a fever? ___ Yes ___ No Have you experienced any sudden weight loss? ___ Yes ___ No

Which activities are difficult to perform: Sitting Standing Walking Bending Lying Down Other

What treatment have you already received for this condition? Chiropractic Medication Surgery Physical Therapy

Name and address of other doctor(s) who have treated you for this condition:

Have you had the same/similar condition in the past? (Please describe):

Health History (Check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Fractures | <input type="checkbox"/> Neurological Disorders |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Headache | <input type="checkbox"/> Pinched Nerve |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Anorexia / Bulimia | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hernia | <input type="checkbox"/> Sinus Issues |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Breast Lumps | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Disorders |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Other(s) |

Date of last physical exam:

List any types of surgeries and/or accidents which you have had and the dates they occurred:

Please list all medications you are taking: Allergies:

Women: Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Daily Habits

What types of exercise do you perform and how often?

What do your daily work habits include? (i.e. sitting, standing, heavy labor, computer work):

What vitamins and nutritional supplements do you take?

Do you smoke and if so, how much per day?

How much liquor do you consume on a weekly basis?

How much coffee, or caffeinated beverages do you consume on a daily basis?

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Energy Chiropractic to release my information including the diagnosis and the records of any treatment or examination rendered to me, or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractors insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf, or that of my dependents. I also understand there is a 24 hr. cancellation policy and I am fully responsible to pay for the visit in full if I miss my scheduled visit without a 24 hr. notice.

SIGNATURE OF PATIENT (OR PARENT IF A MINOR)

DATE