Chiro Care of White Plains

GENERAL INFORMATION-*Please print* Date:_____

Patient Full Name_____ Date of Birth_____

Address_____ care of _____
(Parent or financially responsible person)

City_____ State_____ Zip_____ Phone (home)_____

Driver's Lic # _____ No. Children_____ Phone (work)___ _____

Spouse's Name _____ Spouse's Employer_____

Sex M F	Married Single Widowed Divorced	Social Security Number - -

Patient's Employer or School_____

Address_____

City _____ State_____ Zip _____

*Occupation:*_____ *STUDENT*

Full time Part time *Full time Part time*

Not employed Retired *Non-student*

Who may we thank for referring you

_____

Your Email:

_____

INSURANCE INFORMATION

COMMERCIAL INSURANCE AND MEDICARE ONLY

Primary Insurance Company Name	*Secondary Insurance Company Name*
*(800) Phone #*_____ *Policy/Group #*_____	*(800) Phone #*_____ *Policy/Group #*_____

POLICIES

1. All first visit charges are payable when services are rendered.
2. The fee paid for x-rays, is for analysis only. The film itself is the property of this office. Once films are used for treatment purposes, they cannot be released. Copies can be made if necessary at the expense of those who request them.
3. Method of payment you plan to use to take care of today's charges? ~Cash ~Check ~Credit card

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. Furthermore, I understand Dr. Kobrin will prepare any necessary reports and forms to assist in making collections from my insurance company and that any amount authorized to be paid directly to Dr. Kobrin will be credited to my account upon receipt. However, I clearly understand and agree that all my services rendered me are charged directly to me and I am personally responsible for payment.

Patient Signature_____Date_____

Guardian Signature Authorizing Care_____Date_____

In case of emergency, notify:_____Relationship_____

Address_____ Phone number_____

_____

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NEW PATIENT HISTORY Please fill in appropriate spaces. (Confidential)

Name:_____ Date:_____

MAJOR COMPLAINT:_____

How long have you had this condition?_____Date of Onset_____

Have you lost workdays? YES / NO If yes, how many?_____

Have you had this similar condition before? YES NO If yes, when?_____

Was the injury, accident related? NO / Auto accident / Work accident If yes, when?_____

Previous Chiropractic care? YES / NO Chiropractor's Name:_____

When was your last visit?_____

What was the reason for your initial visit?_____

What spinal maintenance programs were you given to follow to maximize the future stability of you spine?

_____

Did you follow it?_____ If not, why?_____

Why are you changing Chiropractors?_____

What surgeries have you had? _____

_____

List all drugs you now take (prescription and non prescription)._____

_____

Name other doctors you have seen for this condition:_____

What are your health goals?_____

How do you expect to achieve these goals?_____

Please mark if you have had any of these symptoms in the last 12 months:

____Fractured bones
____Auto Accidents
___0-1 yrs ago
___1-5 yrs ago
___5 yrs or more
____Other accidents, falls
____Arthritis
____Diabetes
____Convulsions, epilepsy
____Skin problems
____Cancer
____Frequent colds, flu
____Depressed
____Irritable
____Anemia
____Allergy, sinus
____Under stress
____Eating disorders
____Trouble sleeping
____Trouble concentrating
____Learning disability
____Mood Changes

____Neck pain or stiffness R L
____Numbness/tingling, pain in arms, hands, fingers R L
____Jaw pain or clicks (TMJD) R L
____Difficulty in excessive standing, sitting, riding, bending, lifting, twisting
____Shoulder pain R L
____Dizziness
____Ringing in ears R L
____Hearing loss R L
____Blurred or doubled vision
____Upper back pain, stiffness
____Mid back pain, stiffness
____Lower back pain, stiffness
____Pain with cough, sneeze
____Hip pain R L
____Headaches
____Numbness, tingling, pain in buttocks, legs, feet, toes R L

____Foot trouble R L
____Chest pain, asthma
____Heart problems
____Stroke
____High/low blood pressure
____Varicose veins
____Liver trouble
____Gall bladder trouble
____Digestive problems
____Ulcers
____Hemorrhoids

____Prostate problems
____Impotence
____Kidney trouble

____Menstrual problems (PMS)
____Pregnant (NOW)

____Bed wetting
____Ear Infections
____ AIDS, HIV

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New Patient History

Our patients have had literally dozens of impacts that could cause subluxations. We want to discover several of yours. Please answer the following to the best of your recollection.

1. When was your most recent auto accident?_____

   Speed:_____ Front or Side collision / or Rear-end?_____

   Was treatment received? YES / NO If yes, where?_____

2. When was your most recent stress or strain at work?_____

   Was any treatment needed? YES / NO When was the one before that?_____

   What type of jobs have you done?_____

3. What sport or recreational activities do you do?_____

   When was your most recent stress or strain during your activity?_____

   Was any treatment received? YES / NO When was the one before that?_____

4. Is there any other injury to your spine, minor or major, that the doctor should know about? Explain.

_____

_____

-Vertebral Subluxations can cause pain-

1. Which pain or condition you have circled is the worst?_____
2. How long has it bothered you?_____

3. Vertebral Subluxations can cause irritation to different fibers within nerves. Is your pain sharp or dull?

_____

4. Subluxations can put pressure on the spinal cord which can be constant or occasional. Which do you feel?

_____

5. Pressure on the spinal cord or nerves can be worse in the AM or PM. Which one is harder for you?

_____

6. Does this pain, numbness or tingling radiate into your arms or legs or stay in one area?

_____