Syracuse Performance Chiropractic

900 Burnet Avenue

Syracuse, NY 13203

Date: ____/____/____ Patient's Full Name: _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

☐Male ☐Female Age: _____ Date of Birth: ____/____/____ Social Security #: _____ - _____ - _____

Address: _____ *City:* _____ *State:* _____ *Zip:* _____

How would you like to be addressed by our staff? _____

☐Married ☐Single ☐Widowed ☐Separated ☐Divorced Number of Children: _____ Ages: _____

Occupation: _____ Employer: _____ Business Phone: _____

Emergency Contact: _____ Relationship: _____

Phone: _____ City: _____ State: _____ Zip: _____

Whom may we thank for this referral? _____

Family Physician: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

May our office inform your physician of our exam findings, diagnosis, and treatment plan? ☐Yes ☐No

Payment Method: ☐Cash ☐Check ☐Credit ☐No-interest financing

Insurance Information

Primary Insurance Company: _____ Subscriber's Name: _____

ID#: _____ Group#: _____ Subscriber's DOB: ____/____/____

Secondary Insurance Company: _____ Subscriber's Name: _____

ID#: _____ Group#: _____ Subscriber's DOB: ____/____/____

Work or Auto Accident Information

Is this injury work or auto related? ☐Yes ☐No Date of injury: ____/____/____ Injury reported? ☐Yes ☐No

Claim #: _____ Adjuster Name/Phone #: _____

Name/Address /Phone of Insurance: _____

Name/Address/Phone of Attorney: _____

Chief Complaint

Chief complaint: _____

Secondary or related complaint(s) if any: _____

Was the Onset: ☐Gradual ☐Sudden Since the onset, has it gotten: ☐Worse ☐Better

When did it first occur? _____ Has this occurred before: ☐Yes (#of times: ___ Describe: _____) ☐No

Describe what caused the pain: _____

What does your condition prevent you from normally doing? ☐sitting/driving ☐walking ☐running ☐golfing

☐swimming ☐weight lifting ☐playing with children ☐normal activities of daily living ☐other: _____

What is your long-term goal from treatment (e.g. play a round of golf without pain)? _____

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Describe the quality of the complaint/pain:

- ☐ sharp
- ☐ dull/ache
- ☐ throbbing
- ☐ tingling/numbness
- ☐ burning
- ☐ other: _____

Describe the location of the symptoms:

- ☐ radiating dull, deep ache
- ☐ pin point
- ☐ pain starts localized, but then radiates
  - Describe: _____
- ☐ other: _____

The symptoms are:

- ☐ more prevalent in the morning
- ☐ more prevalent at night
- ☐ better as the day goes on
- ☐ worse as the day goes on

How often daily are you aware of the symptoms:

- ☐ intermittent (less than 25% of time)
- ☐ occasional (25-50% of time)
- ☐ frequent (50-75% of time)
- ☐ constant (75-100% of time)

Does any of the following make the pain worse:

- ☐ lifting/pushing/pulling
- ☐ cough/sneeze/bowel movement
- ☐ driving/riding/sitting
- ☐ walking/running/standing
- ☐ bending forward/leaning back
- ☐ other: _____

Does any of the following make it better:

- ☐ rest/laying down
- ☐ sitting
- ☐ walking/exercise
- ☐ standing
- ☐ other: _____

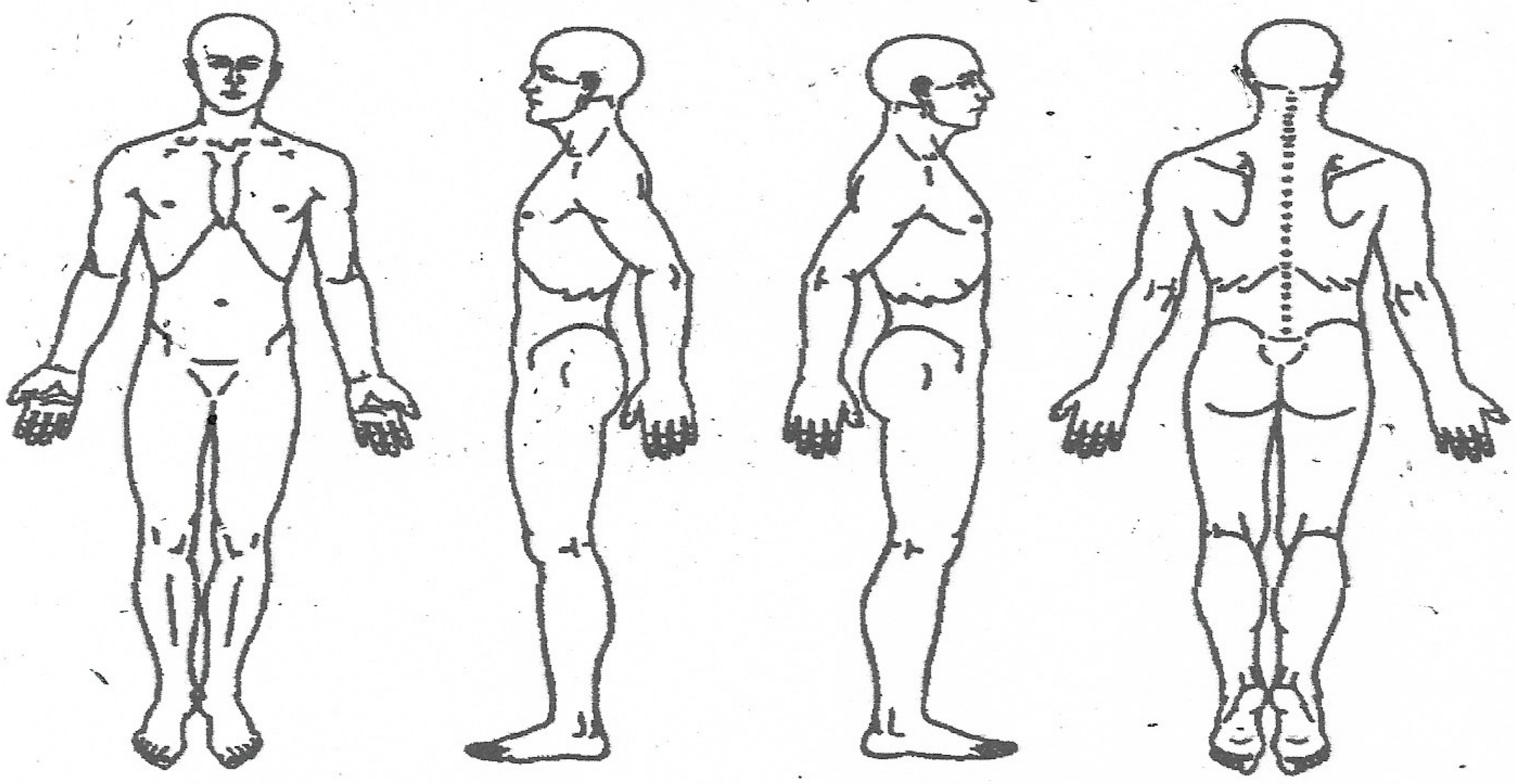
The symptoms feel:

- ☐ better with exercise/activity
- ☐ worse with exercise/activity
- ☐ no change with exercise/activity

Does it interfere with your daily activities:

- ☐ minimal (annoyance, no impairment)
- ☐ slight (tolerated, some impairment)
- ☐ moderate (marked impairment)
- ☐ marked (preclude any activity)

How intense is the pain: ☐Minimal ☐Mild ☐Moderate ☐Severe/Excruciating



Pain Scale

0 1 2 3 4 5 6 7 8 9 10

No pain — Moderate — Severe

Use the following letters to indicate the type and location of discomfort:

A - Aching
B - Burning
N - Numbness/Tingling
P - Pins and Needles
S - Stabbing/Sharp
T - Throbbing
O - Other

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Have you had any changes in bowel or bladder functioning? ☐Yes ☐No

What medications are you currently taking? _____

What vitamins/supplements are you currently taking? _____

Females only: Are you currently pregnant? ☐Yes ☐No

In general, would you say your health is (check one): ☐Excellent ☐Very good ☐Good ☐Fair ☐Poor

Would you be interested in any other services that may help your condition or improve your overall health?

☐Nutritional counseling ☐Vitamins/supplements ☐Rehabilitation ☐Orthotics ☐Exercise/weight loss

Previous Chiropractic Care: ☐Yes ☐No If Yes, for what Problem: _____

What treatment(s) were received: _____ *Were they helpful?* ☐Yes ☐No

Doctor's Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

PAST HEALTH HISTORY

Have you been treated for your present problem in the past? ☐Yes ☐No

If yes, when: _____ *If yes, by whom:* _____ *Outcome:* _____

Please list any major illnesses, injuries, broken bones, hospitalizations, accidents, or surgeries.

Date	Injury/Fracture/Illness/Surgeries	Treatment	Results

Please indicate any of the following illnesses you have had or currently have with approximate dates.

High Blood Pressure_____ Prostate disease_____ Multiple Sclerosis_____

Heart disease_____ Venereal Disease_____ Ulcer_____

Stroke_____ Allergies_____ Cancer_____

Diabetes_____ Scoliosis_____ Serious injury/fall_____

Kidney disease_____ Mental/Emotional_____ Auto accident_____

HIV_____ Seizures_____ Other_____

Signature of Patient: _____ Date:_____