Back To Health Chiropractic
10 Groton Avenue
Cortland, N.Y. 13045
Tel: (607) 753-1884 Fax: (607) 753-1540

NO INSURANCE

Patient Name: ______________________________ D.O.B. ______________ M/F

(circle) Single/Married/Divorced/Separated/Widowed/Other

HOME
Address: ______________________ City: ______________ State: _______ Zip: __________

Student - College Address______________________________________________

Tel# (___)_________________Cell Phone: (___)____________Social Security#: __________

Email address: ______________________________________________

Occupation: __________ Your Employer: ______________________ Phone#: (___) __________

Address:______________________ City: ________________ State: _______ Zip: _______

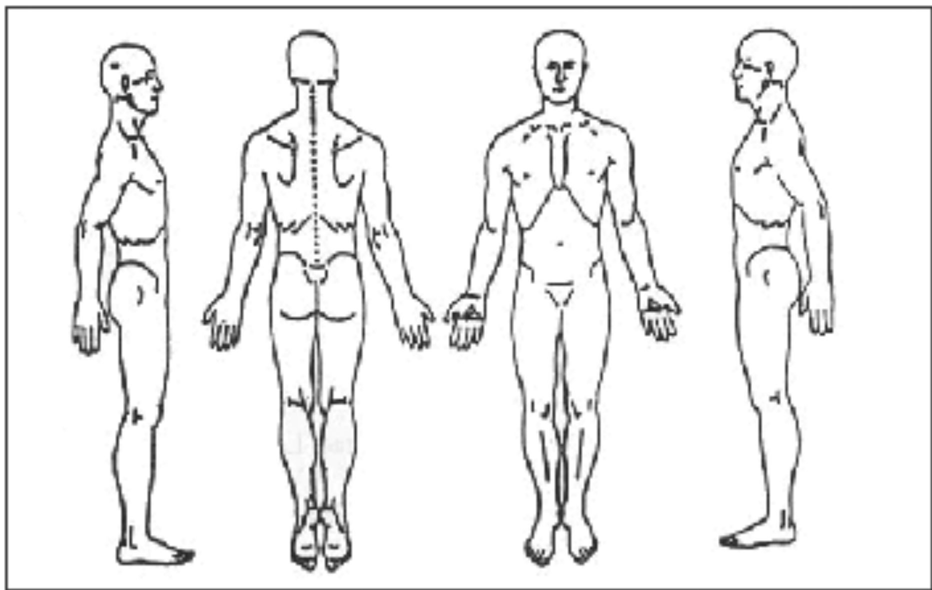
Primary Care Physician Name: ______________________ PCP Phone: __________

Who Referred you here? ______________________________________________

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS

( ) Headache ( ) Neck pain ( ) Mid back pain ( ) Low back pain ( ) Arm/Hand ( ) Leg/Foot

( ) Other ______________________________



Is This? ( ) Work Related ( ) Auto Related ( ) N/A

Date Problem Began: ______________________

How Problem Began: ______________________

CONTINUED ON BACK

Current Complaint (how you feel today)

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable pain

How often are your symptoms present?

Intermittent ( ) 0 – 25% ( ) 26 -50% ( ) 51 – 75% ( ) 76 -100% (Constant)

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? YES/NO

Dates Taken: ___________________________ What areas were taken? _______________________

Facility where taken: ( ) Cortland regional Medical Center ( ) Cayuga Medical Center ( ) other _______________

Height______ Weight________

1.Please check all the following that apply to you:

( ) Numbness in arms/hands legs/feet
( ) Recent Fever
( ) Diabetes
( ) High Blood Pressure
( ) Stroke (date)____________________
( ) Corticosteroid use (cortisone, prednisone, etc.)
( ) Taking Birth Control
( ) Dizziness/Fainting
( ) Thyroid condition
( ) Cancer/Tumor (explain) _______________________
( ) Alcohol
( ) Osteoporosis
( ) Epilepsy/Seizures
( ) Other Health Problems (explain)_____________
______________________________________________

( ) Blood Thinners
( ) Prostate Problems
( ) Menstrual Problems
( ) Urinary Problems
( ) Pregnant? Due date____ births __ vag/C-section
( ) Abnormal Weight ( ) gain ( ) Loss
( ) Marked Morning Pain/Stiffness
( ) Pain Unrelieved by position/rest
( ) Pain at Night
( ) Visual Disturbances
( ) Smoke/packs ________ # of years________
( ) Surgeries ____________________________________
_______________________________________________
( ) Medications: __________________________________

Family History (parents & siblings) ( ) Cancer ( ) Diabetes ( ) High Blood Pressure
( ) Heart Problems/Stroke ( ) Rheumatoid Arthritis

OFFICE POLICY

Payment:
I am aware that all fees for services are my responsibilities and must be paid on the day received.

Cancellations:
If you are unable to keep a scheduled appointment, please notify us at least 2 hours before your scheduled time. Failure to give notice, will result in a $25 charge for the missed appointment.

Returned Check Fee:
There is a $20. fee on all returned checks. This is a fee that our bank charges us to process the returned check.

**I certify to the best of my knowledge, I have read and understand the information on this form. My answers are complete and accurate.**

_______________________________________ ____________________________
Patient's Signature Date