

Back To Health Chiropractic      NO INSURANCE OR NON PARTICIPATING  
120 Tompkins St.  
Cortland, N.Y. 13045  
Tel: (607) 753-1884 Fax: (607) 753-1540

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#: ( ) \_\_\_\_\_

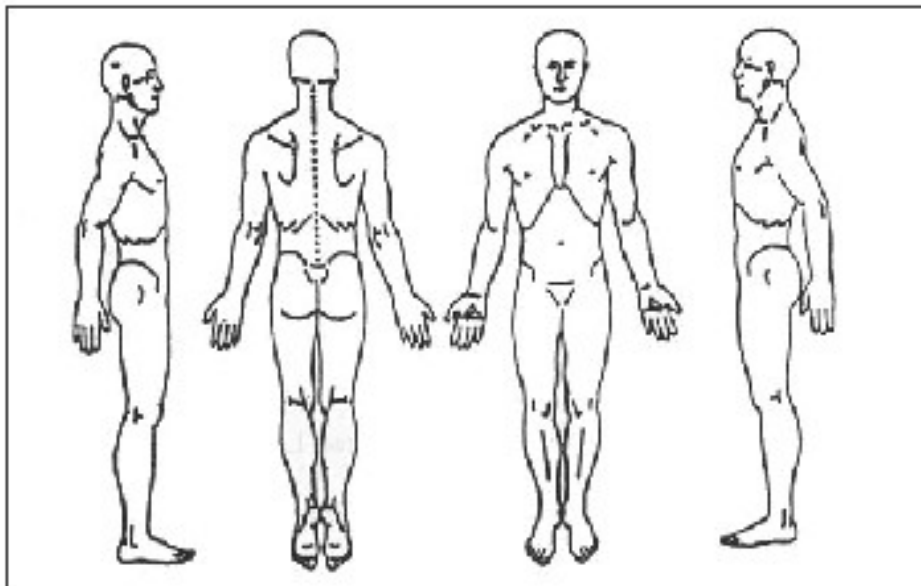
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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 \_\_\_\_\_
- ( ) Surgeries \_\_\_\_\_
- ( ) Medications: \_\_\_\_\_

Family History ( ) Cancer ( ) Diabetes ( ) High Blood Pressure

( ) Heart Problems/Stroke ( ) Rheumatoid Arthritis

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OFFICE POLICY.

Payment:

I am aware that all fees for services are my responsibilities and must be paid on the day received. If you have insurance that Back to Health Chiropractic doesn't participate with and you have out of network benefits, we will provide you with a "superbill" to submit to your carrier and assist you in filing a claim.

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

12/13/23