**NEW CITY CHIROPRACTIC CENTER, LLP**
**DR. MICHAEL COCILOVO | DR. GILBERT RODRIGUEZ**
**490 ROUTE 304 • NEW CITY, NY 10956 • 845-634-8877 • 845-634-0783**
**www.newcitychiropractic.com | info@newcitychiropractic.com**

# PATIENT HISTORY FORM

new city chiropractic center

Today's Date _____

Name_____ Date of Birth _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Phone (Home) _____ (Work) _____ (Cell) _____

Employer_____ Occupation _____

Insurance Company _____ Primary Care Physician _____ Last Visit _____

E-Mail Address _____ Emergency Contact/Phone _____

Height: _____ Weight: _____ Marital Status: (Circle) Married Single Widowed Divorced Separated

Name of Spouse/Significant Other: _____ Ages of your Children: _____

Who referred you to our office? _____

Have you ever had chiropractic care before? No Yes: Who/When? _____

Who is responsible for this bill? (Circle) Self Insurance Workmen's Comp No-Fault Other _____

## *YOUR CURRENT PROBLEM*

**Chief Complaint(s):** *Circle the intensity of each, scale of 1 to 10 with **10 being the worst***

- Headaches: 1 2 3 4 5 6 7 8 9 10
- Shoulder L/R: 1 2 3 4 5 6 7 8 9 10
- Mid-Back: 1 2 3 4 5 6 7 8 9 10
- Leg: 1 2 3 4 5 6 7 8 9 10
- Neck Pain: 1 2 3 4 5 6 7 8 9 10
- Arm L/R: 1 2 3 4 5 6 7 8 9 10
- Lower Back: 1 2 3 4 5 6 7 8 9 10
- Other:_____ 1 2 3 4 5 6 7 8 9 10

**Onset of Problem:** Date ____/____/____ ___Unknown ___Gradual ___Sudden

**Ever had this problem before?** No Yes: When? _____

**How did it start?** *(Circle)* Exertion/Positional Auto Trip/Fall Repetitive Unknown Other:_____

**How long have you had it?** ___ Days ___ Weeks ___ Months ___ Years

**What does it feel like?** Dull/Achy Sharp Burning Shooting/Knifelike
*(Circle all that apply)* Numbness/Tingling Dizziness/Nausea Muscle weakness

**Duration of Symptoms *during a day*?** Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Intermittent (0-25%)

**Worse at a certain time of day?** Morning Afternoon Night No difference

**The pain radiates:** ___No Radiation ___ L-Arm to Elbow ___L-Arm to Hand ___L-Leg to Knee ___L-Leg to Foot
*(Circle all that apply)* ___ R-Arm to Elbow ___R-Arm to Hand ___R-Leg to Knee ___R-Leg to Foot

**How intense is the pain?** No Pain Comes & Goes Mild Moderate Severe

**Are you taking or have taken any medication for this problem?** No Yes:_____

**Are you taking any other medications?** No Yes:_____

**Any vitamins/herbs/supplements?** No Yes:_____

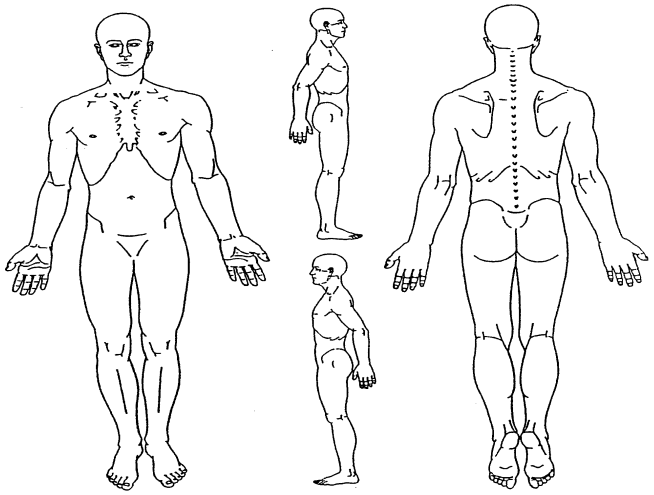
**How is this problem now?:** Rapidly Improving Improving Slowly About the Same Gradually Worsening On & Off

**Any bowel or bladder problems since this problem began?:** No Yes *(Describe)*:_____

**Please tell us if any of these activities are being affected by your current symptoms:**
*Write "B" if you feel BETTER or "W" if you feel WORSE:*

| | | | | | |
|---|---|---|---|---|---|
| ___ Lifting | ___ Bending | ___ Walking | ___ Sitting | ___ Standing | ___ Walking |
| ___ Pushing | ___ Pulling | ___ Reading | ___ Driving | ___ Stairs ↓ | ___ Stairs ↑ |
| ___ Sleeping | ___ Squatting | ___ Reaching | ___ Gripping | ___ Kneeling | ___ Balance |
| ___ Rest | ___ Exercise | ___ Hot | ___ Cold | ___ Other: _____ | |

**Please show us where you are having pain:** *Use lines to illustrate, draw " *** " where you are having numbness or tingling:*



## *PAST HISTORY*

**Any major accidents or injuries?** *(Type, year)* _____

**Any surgeries?** *(Type, year)* _____

**Any allergies?** _____

**Please indicate if you or a family member have had any of the following:** *Write "S" for self, "F" for family member:*

| | | |
|---|---|---|
| ___ Heart Disease | ___ Diabetes | ___ Stroke |
| ___ Cancer | ___ High blood pressure | ___ Asthma |
| ___ Gastrointestinal disease | ___ Memory/mood disorder | ___ Thyroid problem |

**Please indicate if you have or have had any of the following:** *Write "C" for current problem, "P" for past problem:*

| | | |
|---|---|---|
| ___ Visual disturbances | ___ Chest pain | ___ Shortness of breath |
| ___ Ringing in ears | ___ Cold sweats | ___ Nervousness |
| ___ Loss of memory | ___ Sleeping problems | ___ Fainting spells |
| ___ Dizziness | ___ Fainting | ___ Loss of balance |
| ___ Upset stomach | ___ Diarrhea | ___ Constipation |
| ___ Rapid weight change (loss or gain) | ___ Light bothers eyes | ___ Cold hands/feet |
| ___ Numbness in fingers | ___ Numbness in toes | ___ Pins & needles in hands |
| ___ Pins & needles in toes | ___ Excessive fatigue | ___ Sinus problems |
| ___ Loss of smell | ___ Blurred vision | ___ Anemia |
| ___ Gall bladder problems | ___ Indigestion/reflux | ___ Ulcers |
| ___ Painful joints | ___ Kidney problems | ___ Menstrual irregularity/cramps |

Do you smoke? No Yes (amount) _____ **Females: Are you pregnant?** *(Circle)* Yes No Not sure

I fully understand that I am directly and fully responsible to said doctors for all chiropractic bills for services rendered. I hereby authorize my insurance company to pay directly to New City Chiropractic Center the benefits allowable and otherwise payable to my under my current insurance policy, as payment toward the total charges for professional services rendered. This payment shall not exceed my indebtedness to above mentioned assignee and I have agreed to pay in a current manner any balance if said professional service charges are over and above this insurance payment. It is understood and agreed that the amount paid for x-rays is for examination only and the x-ray negatives will remain property of this office, being on file where they may be seen at any time while a patient of this office.

_____ _____
Patient's Signature Date

_____ _____
Signature Authorizing Care Date