

**Owego Chiropractic, P.C.**  
115 Temple Street, Owego NY 13827  
(607)687-3800

## Patient Information

**Patient Name**

Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_

Name you prefer to be called by (nickname) \_\_\_\_\_

Gender M F (circle one) Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Cell Phone Carrier \_\_\_\_\_

Email (home) \_\_\_\_\_ Email (work) \_\_\_\_\_

Preferred method(s) of contact: (check all that apply)

Email (home) \_\_\_\_\_ (work) \_\_\_\_\_ Phone (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

Would you want to be contacted by Text? \_\_\_\_\_ or receive emails from us? \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_

Marital Status: married \_\_\_\_\_ single \_\_\_\_\_ divorced \_\_\_\_\_ separated \_\_\_\_\_ widowed \_\_\_\_\_

Spouse Name: \_\_\_\_\_

**Who Referred you to this office** \_\_\_\_\_

**Emergency Contact**

Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Number(s) where can be reached \_\_\_\_\_

**If you are acting on above patient's behalf please fill out:**

Last name \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Gender M F Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_

### My Certification

I certify that the above information is correct and I request services.

**X** \_\_\_\_\_

Signature of patient or person acting on patient's behalf

Date

### My Privacy

I have received a copy of the Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: 1. Conduct, plan and direct my treatment and follow-up among healthcare providers who may be directly and indirectly involved in providing my treatment; 2. Obtain payment from third-party payers; 3. Conduct normal healthcare operations such as quality assessments and accreditation.

**X** \_\_\_\_\_

Signature of patient or person acting on patient's behalf

Date

# Insurance Information

## My Responsibility

I understand that it is my personal responsibility to verify the chiropractic benefits of my health care coverage before I visit this office.

I also understand that I am personally responsible for all services not paid for by my insurance. All balances unpaid after 60 days will be charged at a rate of 18% annually, 1.5% per month.

## Patient Information

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Relationship to Insured Self Spouse Child other \_\_\_\_\_

## Primary Insurance Information

Policy Holder Information:

Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Employer \_\_\_\_\_  
Address (if different from patient) \_\_\_\_\_

Name of Insurance Provider \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Deductible? (calendar / fiscal) \$ \_\_\_\_\_ Met? Yes No

Co-pay? Yes No If Yes, Amount \$ \_\_\_\_\_

Visit limits per year? (calendar / fiscal) # per year \_\_\_\_\_ Met? Yes No

## Secondary Insurance Information (if applicable)

Policy Holder Information:

Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Employer \_\_\_\_\_  
Address (if different from patient) \_\_\_\_\_

Name of Insurance Provider \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Deductible? (calendar / fiscal) \$ \_\_\_\_\_ Met? Yes No

Co-pay? Yes No If Yes, Amount \$ \_\_\_\_\_

Visit limits per year? (calendar / fiscal) # per year \_\_\_\_\_ Met? Yes No

## My Authorization

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the undersigned physician or supplier for services rendered.

**X** \_\_\_\_\_ Date \_\_\_\_\_  
Signature of patient or person acting on patient's behalf

**Patient Name** \_\_\_\_\_

**Tell us why you are visiting our office today:**

Present symptoms and/or illnesses \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**List your four major health concerns in order of importance:**

1. \_\_\_\_\_ Date of onset \_\_\_\_\_
2. \_\_\_\_\_ Date of onset \_\_\_\_\_
3. \_\_\_\_\_ Date of onset \_\_\_\_\_
4. \_\_\_\_\_ Date of onset \_\_\_\_\_

**Clinical Record**

**Check all the following symptoms which you have now, or have had problems with in the past:**

**E.E.N.T.**

- Asthma
- Crossed Eyes
- Deafness
- Dental Decay
- Earache
- Ear discharges
- Ear noises
- Enlarged glands
- Enlarged Thyroid
- Eye pain
- Failing vision
- Far sightedness
- Frequent colds
- Gum trouble
- Hay fever
- Hoarseness
- Nasal drainage
- Nasal obstruction
- Near sightedness
- Nose bleeds
- Sinus infection
- Sore throat
- Tonsillitis

**Cardiovascular**

- Hardening of arteries
- High blood pressure
- Low blood pressure
- Pain over heart
- Paralytic stroke
- Poor circulation
- Previous heart stroke
- Rapid beating heart
- Slow beating heart
- Swelling of ankles

**Genitourinary Symptoms**

- Bed wetting
- Blood in urine
- Frequent urination
- Inability to control urine
- Kidney infection
- Painful urination
- Prostate trouble
- Pus in urine

**General Symptoms**

- Allergic
- Allergy
- Chills
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Loss of sleep
- Loss of weight
- Migraine
- Nervousness
- Neuralgia
- Numbness or pain in arms, hands, or legs
- Obesity
- Sweats
- Tension
- Wheezing

**Skin**

- Bruises easily
- Dryness

- Eczema
- Hives or allergy
- Itching
- Psoriasis
- Sensitive skin
- Skin eruptions
- Varicose veins

**For Women Only**

- Congested in breast
- Excessive flow
- Hot flashes
- Infertility
- Irregular cycle
- Lumps in breast
- Menopausal symptoms
- Painful menstrual periods
- Premenstrual headache
- Previous miscarriage
- Vaginal discharge

**Gastrointestinal Symptoms**

- Belching or gas
- Colitis
- Colon trouble
- Constipation
- Diarrhea
- Distension of abdomen
- Difficult digestion
- Excessive hunger
- Hemorrhoids (piles)

- Gall Bladder trouble
- Jaundice
- Liver trouble
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting
- Vomiting of blood

**Muscle & Joint Symptoms**

- Arthritis
- Back ache
- Back spasms
- Difficulty walking
- Disc displacement
- Faulty posture
- Foot trouble
- Hernia
- Muscle spasms
- Pain between shoulders
- Pain in neck
- Painful joints
- Painful tailbone
- Sciatica
- Spinal curvature
- Stiff neck
- Swollen joint
- Tremors

**Respiratory**

- Chest pain
- Chronic cough
- Difficulty breathing
- Spitting up blood
- Spitting up phlegm

# Personal History

Patient Name \_\_\_\_\_

Have you had any of the following diseases? Please circle.

- |              |             |               |                 |                 |
|--------------|-------------|---------------|-----------------|-----------------|
| Alcoholism   | Chicken Pox | Goiter        | Measles         | Pneumonia       |
| Anemia       | Diabetes    | Heart Disease | Mental Disorder | Polio           |
| Appendicitis | Eczema      | Influenza     | Mumps           | Rheumatic Fever |
| Arthritis    | Epilepsy    | Lumbago       | Pleurisy        | Tuberculosis    |

Have you been hospitalized? \_\_\_\_\_

Have you had any surgeries? \_\_\_\_\_

Accident or falls? Knocked unconscious or stunned? (describe fully) \_\_\_\_\_

Fractures or dislocations \_\_\_\_\_

List any medications you take \_\_\_\_\_

How many hours do you generally sleep? \_\_\_\_\_

Do you drink coffee? \_\_\_ Tea? \_\_\_ Alcohol? \_\_\_ Use recreational drugs? \_\_\_ Exercise? \_\_\_

**Family History** Please tell us about your family history. Circle or check everything that applies. If someone is deceased, please circle "D" ("L" for still living) and write in the cause of death.

- Heart Disease
- Stroke
- Cancer
- Diabetes
- Rheumatoid Arthritis
- Multiple Sclerosis
- Lung Disease
- Bone Disease

		Heart Disease	Stroke	Cancer	Diabetes	Rheumatoid Arthritis	Multiple Sclerosis	Lung Disease	Bone Disease
Father	L D Cause:								
Mother	L D Cause:								
Grandfather (Paternal)	L D Cause:								
Grandmother (Paternal)	L D Cause:								
Grandfather (Maternal)	L D Cause:								
Grandmother (Maternal)	L D Cause:								
Sibling M F	L D Cause:								
Sibling M F	L D Cause:								
Child M F	L D Cause:								
Child M F	L D Cause:								

# Pain Scale

Patient Name \_\_\_\_\_

Circle the number that best describes the question being asked.

1. What is the level of your pain **right now**?

No Pain   1     2     3     4     5     6     7     8     9    10   Worst possible pain

2. What is your **typical** or **average** pain?

No Pain   1     2     3     4     5     6     7     8     9    10   Worst possible pain

3. What is your level of pain **at its best**?

(How close to "0" does your pain get when it bothers you **least**?)

No Pain   1     2     3     4     5     6     7     8     9    10   Worst possible pain

4. What is your pain level **at its worst**?

No Pain   1     2     3     4     5     6     7     8     9    10   Worst possible pain

## Pain Drawing

Circle the location of your pain on the body outlines below. Use the initials to signify your specific symptoms.

**A – Ache**

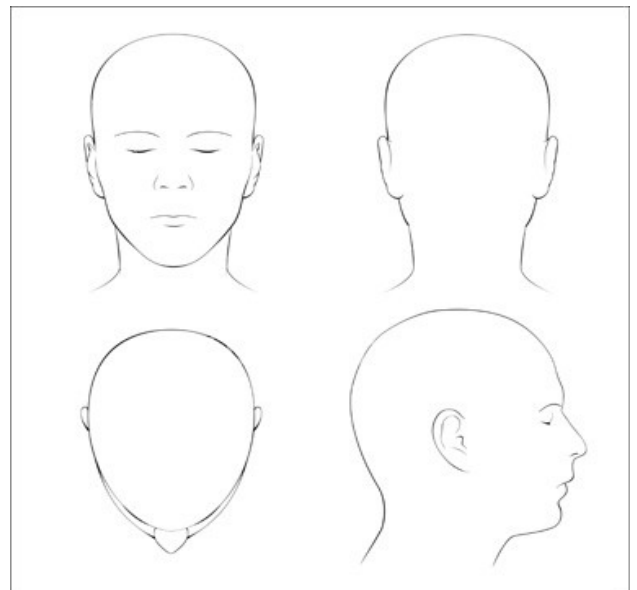
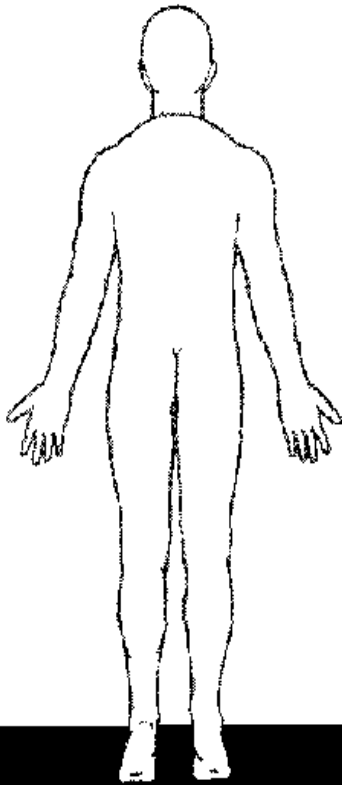
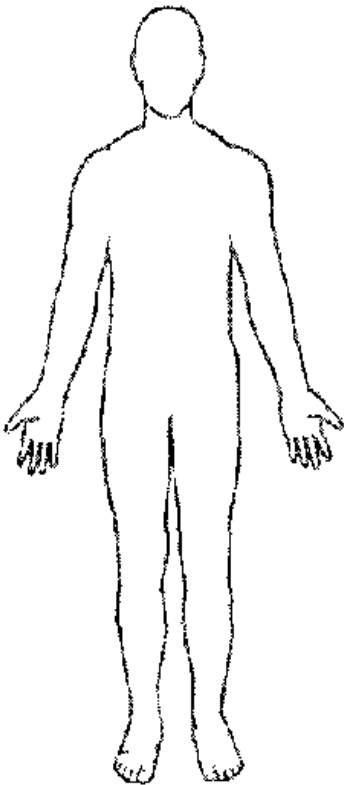
**B – Burning**

**N – Numbness**

**P – Pins & Needles**

**S – Stabbing**

**O – Other**



**Front**

**Back**

