

Date: \_\_\_ / \_\_\_ / \_\_\_

**Patient Information**

Patient: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Statement Emailed?  Yes  No IF YES EMAIL BELOW  
 Email Address: \_\_\_\_\_  
 Appt. Reminders  Yes  No Cell Phone Carrier: \_\_\_\_\_  
 Patient's Home Phone: \_\_\_\_\_  
 Patient's Cell Phone: \_\_\_\_\_  
 Patient's Work Phone: \_\_\_\_\_  
 Sex:  M  F Age \_\_\_\_\_ Birth date \_\_\_ / \_\_\_ / \_\_\_  
 Single  Married  Widowed  Separated  Divorced

Patient's SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Employer Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_  
 DOB: \_\_\_ / \_\_\_ / \_\_\_ Occupation: \_\_\_\_\_  
 Spouse's Employer: \_\_\_\_\_

**Phone Numbers Fill Out Information Below**

**If minor who do we contact regarding insurance information:**  
 Name: \_\_\_\_\_ Ph: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**In Case of an Emergency, Contact:**  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Home: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**\*\*Whom May We Thank for Referring You to Our Office\*\***  
 Name: \_\_\_\_\_ \*\*

**Patient Symptoms and Other Information Below**

Reason for your visit: \_\_\_\_\_  
 When did your symptoms appear? \_\_\_\_\_  
 Is this condition getting progressively worse?  Yes  No  Unknown  
 Are you presently working?  Yes  No if no last date worked \_\_\_ / \_\_\_ / \_\_\_  
 Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): \_\_\_\_\_  
 Circle type of pain: Sharp Dull Throbbing Numbness Aching Shooting \_\_\_\_\_  
 Burning Tingling Cramps Stiffness Swelling Other \_\_\_\_\_  
 How often do you have this pain? \_\_\_\_\_  
 Is it constant or does it come and go? \_\_\_\_\_

**Have you ever seen a chiropractor before:**  Yes  No if yes, Whom: \_\_\_\_\_  
**Is this a result of a Workers Comp Injury?**  Yes  No **Is this a result of a No-Fault Injury?**  Yes  No

**Primary Care Physician Name:** \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_, Zip: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Would you like Dr. Cunningham's notes sent to this physician:** Yes  No   
**Would you like Dr. Cunningham's office to send notes to another provider:** Yes  No   
**Would you like a Clinical Summary of your visit emailed to you?** Yes  No  if yes: email: \_\_\_\_\_

**Primary Insurance**

Who is subscriber: \_\_\_\_\_ Insured's DOB \_\_\_ / \_\_\_ / \_\_\_  
 Insurance Co: \_\_\_\_\_  
 Insurance ID #: \_\_\_\_\_  
 Group #: \_\_\_\_\_ SSN of insured: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Is Patient covered by Additional Insurance?  Yes  No

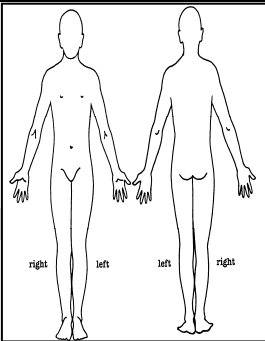
Secondary Ins: \_\_\_\_\_ DOB \_\_\_ / \_\_\_ / \_\_\_  
 ID#: \_\_\_\_\_ Group#: \_\_\_\_\_  
 Third Insurance: \_\_\_\_\_

Name of NF/WC Ins Carrier: \_\_\_\_\_  
 Workers Comp Clm#: \_\_\_\_\_  
 No-Fault Clm#: \_\_\_\_\_  
**Date of Injury:** \_\_\_ / \_\_\_ / \_\_\_

**Assignment and Release:**

I, the undersigned certify that I (or my dependent have insurance coverage with \_\_\_\_\_ and assign directly to Dr. George Cunningham all insurance benefits, if any, otherwise payable to me for services rendered. I know that I am financially responsible for all charges including durable medical equipment and supplements whether or not paid by insurance. If the account goes to collections, I understand that I am responsible for any and all collection fees. I hereby authorize the doctor to release all information necessary to secure the benefits. I authorize the use of this signature on all insurance submissions. **I also understand a quote of benefits does not guarantee payment.** Payment of insurance benefits are subject to terms, limitation, and the plan exclusions at the time services are rendered.

Responsible Party Signature: \_\_\_\_\_  
 Relationship: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_



**Health History**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Last Spinal Exam: \_\_\_\_\_ MRI: \_\_\_\_\_  
 Last Physical Exam: \_\_\_\_\_ CT: \_\_\_\_\_ Scan Bone Scan: \_\_\_\_\_ Spinal X-Ray: \_\_\_\_\_  
 What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy  Massage  
 Chiropractic Services  None  Other \_\_\_\_\_  
 Name and address of other doctor(s) who have treated you for your condition: \_\_\_\_\_  
 \_\_\_\_\_

Check Box "Yes or "No" to indicate if you have had any of the following: Check Box F to indicate family history of the following:

AIDS/HIV Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	Multiple Sclerosis Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	<b>Are you pregnant?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Due Date: _____
Anemia Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	Mumps Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	Number of Children: _____
Arthritis Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	Osteoporosis Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	Any Prior History of Neck or Back Injuries: <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	Pacemaker Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	If Yes, Explain: _____
Bleeding Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	Parkinson's Yes <input type="checkbox"/> No <input type="checkbox"/>	
Cancer Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	Pinched Nerve Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	
Chemical Depend Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	Pneumonia Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	<b>Habits:</b>
Emphysema Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	Polio Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	Smoking <input type="checkbox"/> Packs/Day: _____
Epilepsy Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	Prostate Problems Yes <input type="checkbox"/> No <input type="checkbox"/>	Alcohol <input type="checkbox"/> Drinks/Week: _____
Fractures Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	Psychiatric Care Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	Coffee/Caffeine Drinks <input type="checkbox"/> Cups/Day: _____
Goiter Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	Rheumatoid Arthritis Yes <input type="checkbox"/> No <input type="checkbox"/>	High Stress Level <input type="checkbox"/> Reason: _____
Diabetes Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	Migraines Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	
Gout Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	Rheumatic Fever Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	<b>Exercise:</b>
Heart Disease Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	Allergy to heat/cold Yes <input type="checkbox"/> No <input type="checkbox"/>	None <input type="checkbox"/>
Hepatitis Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	Scarlet Fever Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	Moderate <input type="checkbox"/>
Hernia Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	Stroke Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	Daily <input type="checkbox"/>
Herniated Disk Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	Thyroid Problems Yes <input type="checkbox"/> No <input type="checkbox"/>	Heavy <input type="checkbox"/>
High Cholesterol Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	Tonsillitis Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	
Kidney Disease Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	Tuberculosis Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	<b>Work Activity:</b>
Liver Disease Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	Tumor Growths Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	Sitting <input type="checkbox"/>
Measles Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	Ulcers Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	Standing <input type="checkbox"/>
Miscarriage Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	COVID-19 Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>	Light Labor <input type="checkbox"/>
Mononucleosis Yes <input type="checkbox"/> No <input type="checkbox"/> F <input type="checkbox"/>		Heavy Labor <input type="checkbox"/>

STAFF ONLY: Reviewed

**Injuries/Surgeries you have had**

**Falls:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Head Injuries:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Broken Bones/Dislocations::** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Surgeries:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Medications	Allergies	Vitamins/Herbs/Minerals
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Consent to Communicate Information to an Authorized Person**

This allows you to name a person (such as your spouse, partner, other family member or friend) to communicate on your behalf with Cunningham Chiropractic. This form when signed allows Cunningham Chiropractic to speak to this authorized person about your personal information concerning insurance benefits, payments, treatment or any other health care information regarding your care. I \_\_\_\_\_ (your name) hereby give my consent for Cunningham Chiropractic to communicate personal information on my behalf to the authorized person(s) named below. I may revoke this authorization at any time in writing to Cunningham Chiropractic 210 Old Bridge Street East Syracuse NY 13057. This authorization allows Cunningham Chiropractic to speak with the authorized person(s) regarding: Treatment, insurance benefits, copays or any other aspects regarding care.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Person(s) Authorized to speak with Cunningham Chiropractic**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_