Cunningham Chiropractic Welcome To Our Office

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: _____ **

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 Cunningham Chiropractic 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: _____/____/_____

Patient Symptoms and Other Information Below

Reason for your visit: _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐Yes ☐No ☐Unknown

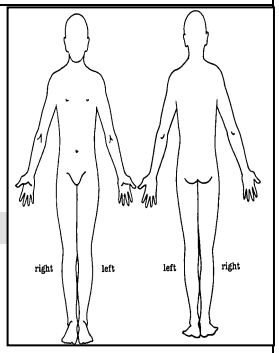
Are you presently working? ☐Yes ☐No if no last date worked _____/_____/_____

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

Mark an X on the picture where you continue to have pain numbness, or tingling



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 Cunningham Chiropractic to notes sent to this physician: Yes☐ No☐

Would you like Cunningham Chiropractic 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: _____

----------**Complete Back Side**----------→

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☐ No☐ F☐
Anemia Yes☐ No ☐ F☐
Arthritis Yes ☐ No ☐ F☐
Asthma Yes☐ No ☐ F☐
Bleeding Yes☐ No ☐ F☐
Cancer Yes☐ No ☐ F☐
Chemical Depend Yes☐ No ☐
Emphysema Yes☐ No ☐ F☐
Epilepsy Yes☐ No ☐ F☐
Fractures Yes☐ No ☐ F☐
Goiter Yes ☐ No ☐ F☐
Diabetes Yes☐ No ☐ F☐
Gout Yes ☐ No ☐ F☐
Heart Disease Yes☐ No ☐ F☐
Hepatitis Yes☐ No☐ F☐
Hernia Yes☐ No☐ F☐
Herniated Disk Yes☐ No☐ F☐
High Cholesterol Yes☐ No☐F☐
Kidney Disease Yes☐ No☐ F☐
Liver Disease Yes☐ No☐ F☐
Measles Yes☐ No☐ F☐
Miscarriage Yes☐ No☐ F☐
Mononucleosis Yes☐ No☐ F☐
Multiple Sclerosis Yes☐ No☐F☐
Mumps Yes☐ No☐F☐
Osteoporosis Yes☐ No☐ F☐
Pacemaker Yes☐ No ☐ F☐
Parkinson's Yes☐ No☐
Pinched Nerve Yes☐ No☐F☐
Pneumonia Yes ☐ No☐F☐
Polio Yes ☐ No ☐ F☐
Prostate Problems Yes ☐ No☐
Psychiatric Care Yes ☐No ☐F☐
Rheumatoid Arthritis Yes☐ No☐
Migraines Yes☐ No ☐ F☐
Rheumatic Fever Yes ☐No ☐F☐
Allergy to heat/cold Yes☐ No ☐
Scarlet Fever Yes ☐ No ☐ F☐
Stroke Yes ☐ No ☐ F☐
Thyroid Problems Yes ☐ No ☐
Tonsillitis Yes ☐ No ☐ F☐
Tuberculosis Yes☐ No ☐ F☐
Tumor Growths Yes ☐ No ☐ F☐
Ulcers Yes ☐ No☐ F☐
COVID-19 Yes ☐ No☐ F☐

Are you pregnant? Yes ☐ No ☐ Due Date:_____
Number of Children:_____

Any Prior History of Neck or Back Injuries: ☐ Yes ☐ No
If Yes, Explain: _____
_____

Habits:
Smoking ☐ Packs/Day: _____
Alcohol ☐ Drinks/Week: _____
Coffee/Caffeine Drinks ☐ Cups/Day: _____
High Stress Level ☐ Reason: _____

Exercise:
None ☐
Moderate☐
Daily☐
Heavy☐

Work Activity:
Sitting☐
Standing☐
Light Labor☐
Heavy Labor☐

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: _____