

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#: _____ - _____ - _____ (REQUIRED)
 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 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: _____

Primary Insurance

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

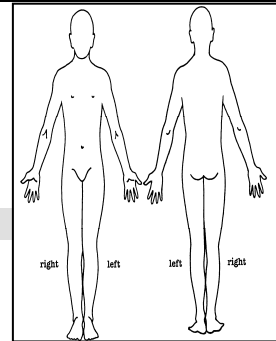
Is Patient covered by Additional Insurance? Yes No

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: ___/___/___



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

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, P.C. This form when signed allows Cunningham Chiropractic, P.C. 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, P.C. 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, P.C. 210 Old Bridge Street East Syracuse NY 13057. This authorization allows Cunningham Chiropractic, P.C. 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, P.C.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____