Confidential Patient Information

Barnes Chiropractic
732 Pittsford-Victor Road, Pittsford 14534
585-267-7181 / Fax 585-267-7704

Patient Information

Last Name	First Name	MI	Gender	Age	Birth Date
			M F		

Address	City	State	Zip

Home Phone #	Work Phone #	Cell #	Email

In case of an emergency contact	Marital Status	#of Children	Social Security #
	M S W D		

Referred By	Employer	Address	Phone

Primary Care Physician Information

Doctor's Last Name	First Name	Phone #

Address	City	State	Zip

Have you seen your primary doctor for this complaint?	Date of Last Physical Exam:	Was exam normal, if not please explain:
☐ No ☐ Yes, Date:_____		

Insurance Information

Insurance Carrier	Policy #	Group #

Name of Subscriber	Birth Date	SSN

Is your condition due to	If yes, when and where did the accident occur?
☐ Work ☐ Auto ☐Other	

Auto / Workers Comp Insurer	Phone #	Claim#

Employer and Address

I hereby direct _____ to pay by check made out and mailed directly to Alicia L Barnes, at the above address. My signature below is a direct assignment of my rights and benefits under this policy. I also authorize the release of any information pertinent to my case to any insurance company, adjustor, or attorney involved in this case.

Payment is expected at the time services are rendered. Keep in mind that the financial obligation for chiropractic treatment is between you and our office and is not dependent upon insurance coverage. We will provide you with receipts with pertinent information for you to be reimbursed by your insurance company. Barnes Chiropractic is not participating with Medicare, however, we will file the necessary forms and payment will be mailed to you.

As a patient of this office you agree to keep all your appointments. If for some reason you need to reschedule your appointment please contact our office within 24 hours or a $40.00 charge will be applied to your account, which is not covered by insurance. Please reschedule all missed appointments within 7 days in compliance with your care-plan.

This office accepts cash, check, Visa, Mastercard, and Discover. Any checks returned for insufficient funds will be charged a $30.00 fee. Any unpaid, unresolved balances will be forwarded to our collections agency after 30 days.

Patient's Signature:_____ Date_____

Drs. Initials_____

Date _____

Family History

Do you have a family history of Cancer, Heart disease, Diabetes, Auto-immune Conditions or Arthritis?
(If yes, please list family member, whether living, age and condition of disease.)

_____

_____

Previous Medical History

Surgeries, Hospitalizations, Serious Illnesses (List Year in Brackets):_____

_____

Fractures, Dislocations, Major Dental Work (List Year in Brackets):_____

_____

Have you been in an auto accident: past year past 5 years over 5 years never
If yes, briefly describe _____

_____

Have you had any other personal or job related injury or accident? past year past 5 years over 5 years never
If yes, briefly describe _____

Current Health Information

Have you had previous Chiropractic Care? If so, when was your last visit? _____

Name and Contact of Chiropractic Office? _____

What is your major complaint? _____

Was this complaint precipitated by a specific event/incident?_____

Have you had this or similar conditions in the past? _____

When did this condition first begin:_____ Is it getting progressively worse: Yes No Constant Comes and Goes

Is this condition interfering with your: Work Sleep Daily Routine Other_____

What activities aggravate your condition?_____

Have you seen any other doctors for this condition? _____

Are you currently being treated for any other medical conditions? If yes please list condition and treating doctor(s).

_____

Are you currently taking any medication or vitamin supplements? If yes, please list. _____

_____

Drs. Initials_____ Patients Initials _____
Date_____ Date_____

Please list all symptoms that you are experiencing today. Rate the severity and frequency of the symptom using the scale below each line.

1) Symptom - _____ Onset Date_____

No pain -0 1 2 3 4 5- Extreme Pain Frequency: Occasional Intermittent Frequent Constant

What makes it feel better?_____ What makes it feel worse?_____

2) Symptom - _____ Onset Date_____

No pain -0 1 2 3 4 5- Extreme Pain Frequency: Occasional Intermittent Frequent Constant

What makes it feel better?_____ What makes it feel worse?_____

3) Symptom - _____ Onset Date_____

No pain -0 1 2 3 4 5- Extreme Pain Frequency: Occasional Intermittent Frequent Constant

What makes it feel better?_____ What makes it feel worse?_____

4) Symptom - _____ Onset Date_____

No pain -0 1 2 3 4 5- Extreme Pain Frequency: Occasional Intermittent Frequent Constant

What makes it feel better?_____ _____ What makes it feel worse?_____

Pain Diagram

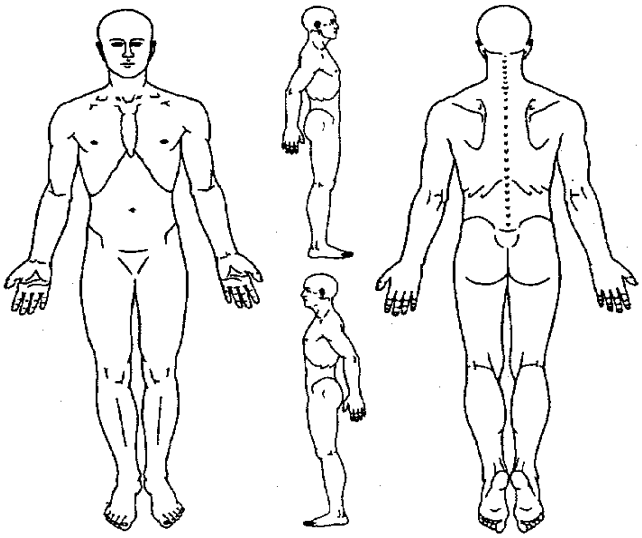
On the following diagram, please indicate all areas of

Pain – XXX

Stiffness - ///

Numbness – OOO

Other (specify) - _____



Drs. Initials_____ Patients Initials _____

Date_____ Date_____