

First Visit Date: _____

Patient Information

Tri-County Chiropractic, PC, 7700 Pittsford-Palmyra Road, Fairport, NY 14450, (585) 425-9820

Patient to complete the following sections:

Patient Last Name	First Name	MI	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Age	Date of Birth
Patient Address		City		State	Zip Code
Home Phone #	Work Phone #		Height	Weight	
In case of emergency contact:	Marital Status <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> S <input type="checkbox"/> W	# of Children		Social Security #	
Referred By:	Previous chiropractic care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient Email: <i>(Always Kept Private)</i>			

Insurance Information:

Insured Last Name	First Name	MI	Insurance ID #	Date of Birth
Employer		Insurance Company Name		
Is Illness or injury related to: <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Other	Do you have secondary insurance that might cover this injury/illness: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, other insurance company name:	

Primary Care Physician Information:

Doctor's Last Name	First Name	Have you seen your primary doctor for this complaint? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____		
Address	City	State	Zip Code	Phone Number

History of Injury or Current Complaint:

Please briefly describe your injury or current complaint and date of onset: _____

When does your complaint feel worse? AM PM Please explain: _____

Does your pain interrupt your sleep? No Yes Please explain: _____

What activity is affected most due to this complaint? _____

Previous Conditions and Treatment:

Please briefly list any previous medical conditions and treatment: _____

List all medications and supplements: _____

Do you have any allergies NO YES Please explain: _____

List all dates of hospital visits and/or types of surgeries: _____

Are any of these conditions in your family history? Autoimmune disorders Cancer GI disorders
 Heart disease Neurological Arthritis Diabetes Kidney disease Seizures

I certify that the above information is true and correct to the best of my knowledge and I hereby consent to the release of my confidential medical and patient information in the possession of the practitioner named above to other health professionals to whom I am referred and to the insurance company or other entity responsible for payment, utilization and/or quality review for all or a portion of my care.

Signature _____ Today's date: ____/____/____

If patient required assistance to complete this form, sign your name and state relationship (i.e.,parent, translator)

Name _____ Relationship _____ Today's date: ____/____/____

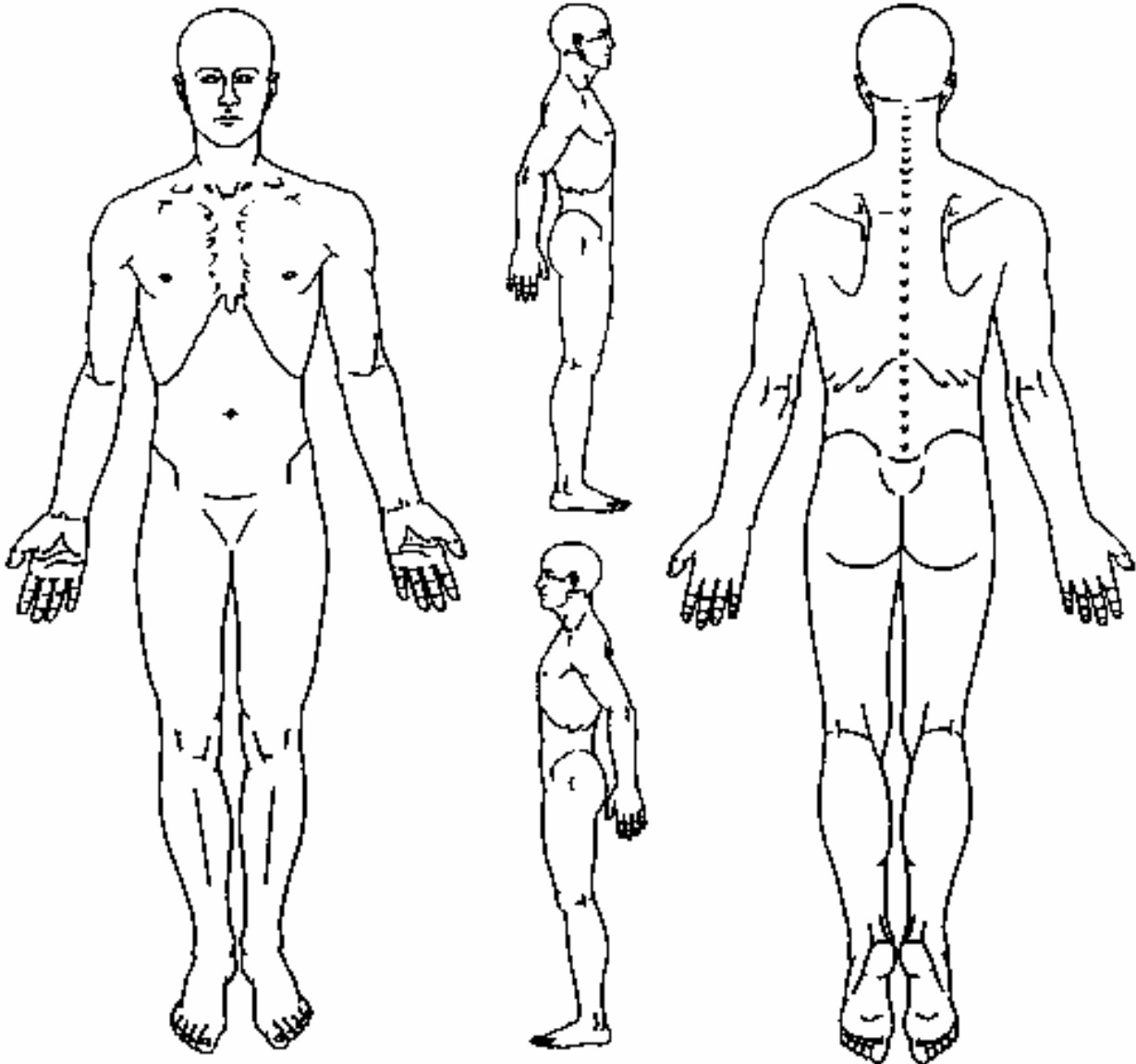
Pain Diagram

NAME _____

DATE _____

How long have you had neck pain _____ years _____ months _____ weeks

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now. Please complete both sides of this form.



A = ACHE

B = BURNING

N = NUMBNESS

P = PINS & NEEDLES

S = STABBING

O = OTHER

Patient Signature