CONFIDENTIAL HEALTH INFORMATION

Peak Performance Chiropractic
Dr. Eric Luper
319 Broadway
Menands, NY 12204
518.472.9130
www,ppcalbany.com

Today's Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ SSN: _____ Gender ○ male ○ female

Address: _____

City, State, Zip: _____

Marital Status ○ Single ○ Married ○ Divorced ○ Widowed ○Separated

Email address: _____ Phone #: _____ Cell #: _____

Emergency Contact: _____ Relationship: _____ Contact #: _____

Your Occupation: _____ Employer: _____

Spouse's Name: _____ Employer: _____

Children (Names and Ages): _____

Insurance Carrier: _____ Policy #: _____

Primary Care Provider: _____ Insured's Name: _____

Insured's Employer: _____ Who carries policy? ○ self ○ spouse ○ parent

Address: _____

Claim Number (if available): _____ Do you have secondary insurance? ○ yes ○ no

Please ensure we have copies of all primary and secondary insurance cards as well as photo ID.

Have you consulted a chiropractor before? ○ yes ○ no

If so, who and when? _____

Where did you find out about our office? ○ Referral by friend/relative ○ Insurance manual/website ○ Internet ○ Sign/Advertisement ○ other _____

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Patient Name: _____

Location of Pain: _____

How the problem occurred: ○ Accident (Work/Auto/Other: _____)
○ Gradual onset ○ Sudden Onset

When did the problem start? _____ Intensity 0-○-○-○-○-5-○-○-○-○-10

Pain is ○ Constant ○ Comes and goes If so, how often and when? _____

Description of pain: ○ Sharp ○ Achy ○ Dull ○ Stiffness ○ Stabbing
○ Numb/Tingle ○ Cramping ○ Burning ○ Shooting ○ Throbbing
○ Other: _____

Does the pain travel, shoot or radiate? _____

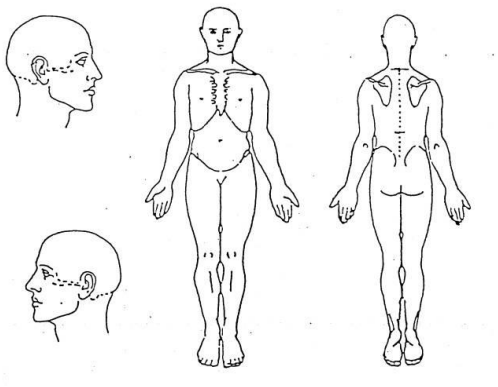
What worsens the pain? _____

What lessens the pain? _____

What have you already tried to relieve the problem? ○ Heat/Ice ○ Massage ○ Physical Therapy
○ Surgery ○ Over-the-counter meds ○ Prescription meds ○ Surgery ○ Acupuncture
○ Chiropractic ○ Stretching ○ Other: _____

Does the pain interfere with your: ○ Work/Career ○ Household Activity ○ Recreation
○ Sleep ○ Personal Relationships

Mark your pain on the following diagram:



Does the condition affect:

Sitting	○ Y ○ N	Standing	○ Y ○ N
Rising	○ Y ○ N	Walking	○ Y ○ N
Lying Down	○ Y ○ N	Bending	○ Y ○ N
Computer	○ Y ○ N	Stairs	○ Y ○ N
Driving	○ Y ○ N	In/Out of Car	○ Y ○ N
Turning Head	○ Y ○ N	Shopping	○ Y ○ N
Lifting	○ Y ○ N	Reaching	○ Y ○ N
Exercise	○ Y ○ N	Overhead	○ Y ○ N

Have you had any of the following (or have now)?

○ AIDS/HIV	○ Emphysema	○ Herniated Disc	○ Lyme Disease
○ Alcoholism	○ Epilepsy	○ High Cholesterol	○ Mononucleosis
○ Allergies	○ Fractures	○ Low Bone Density	○ Stroke
○ Anemia	○ Glaucoma	○ Kidney Problems	○ Ulcers
○ Arteriosclerosis	○ Gout	○ Dizziness	○ Tuberculosis
○ Arthritis	○ Heart Disease	○ Prostate Disease	○ Tumors/Polyps
○ Asthma	○ Hepatitis	○ Pinched Nerve	○ Scoliosis
○ Diabetes	○ Hernia	○ Migraines	○ TMJ Problems
○ Sudden Weight Loss	○ Ear Infection	○ Loss of bowel/bladder function	

Other: _____

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Social History

Alcohol use	○ Daily ○ Weekly How much? _____	Job Pressure	0-○-○-○-○-5-○-○-○-○-10
Coffee use	○ Daily ○ Weekly How much? _____	Exercise	0-○-○-○-○-5-○-○-○-○-10
Tobacco use	○ Daily ○ Weekly How much? _____	Relaxation	0-○-○-○-○-5-○-○-○-○-10
Pain Relievers	○ Daily ○ Weekly How much? _____	Hobbies:	_____
			_____

Please initial the following:

- I instruct the doctor to deliver the care that in his professional opinion will best help me in the restoration of my health. I understand that the care offered at this office is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is separate and distinct from medicine and does not proclaim to cure any organic disease. ☐
- I may request a copy of the office's Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties. ☐
- I realize that an x-ray examination may be hazardous to an unborn child. I certify to the best of my knowledge I am not pregnant. Date of last menstrual period: _____ ☐
- I give permission to be called to confirm or reschedule appointments and to be sent occasional cards, letters or emails of health information as an extension of my care in this office. ☐
- I understand that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered service I receive. ☐
- To the best of my knowledge and ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern. ☐

If the patient is a minor child, print the child's full name: _____

Signature: _____ Date: _____