WNY SPINAL SOLUTIONS NEW PATIENT PAPERWORK

Name:_________________________________ Date:________________

Social Security Number:____________________Date of Birth:__________

Address:_________________________City:______________Zip:______

Cell:(___)______________________Home:(___)___________________

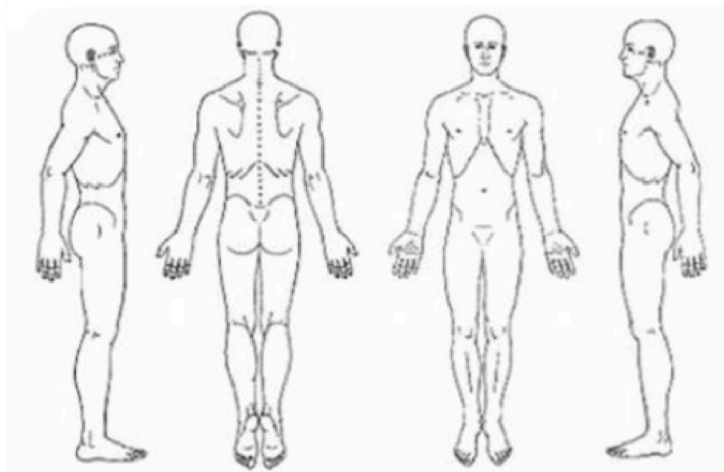
Occupation:____________________Employer:____________________

Marital Status:____________ Children: Y/N Ages:________________

Email:______________________ Referred by:_____________________

PRESENT COMPLAINTS (Circle all that apply)

Headache	Upper back pain	Fainting
Mental Dullness	Midback pain	Blurry/Double Vision
Loss of Memory	Rib Pain	Irritability
Dizzy	Shortness of breath	Ears Ringing/Buzzing
Fear	Loss of Smell/Taste	Unbalanced
Pins/Needles in Arms/Hands	Confusion	Hands Cold
Pins/Needles in Legs/Feet	Eye Strain/Pain	Chest Pain
Depression	Neck Pain	Low back Pain
Nervousness		



Please circle the areas where you have symptoms on the diagram to the left. Use this key to describe your symptoms.

S=Sharp
A=Achy
D=Dull
N=Numb
T=Tingling
B=Burning

How constant are your symptoms?

Constant
Frequent
Intermittent
Occasional

Name:____

Medications:

Please list all medications you currently take.

____

____

____

Supplements:

Please list all supplements you currently take.

____

____

Allergies:

____

____

Smoking:

____________ packs/day _____________ years

Drinking:

____________ drinks/week

Sleep:

____________ hours/night

 # Meals/Day:

____

 # Days of Exercise/Week:

____

Type(s) of Exercise:

____

Amount of Water Consumed Daily:

_________ oz.

Stress Level: Low Moderate High

Name:____

Surgical History:

Please list ALL previous surgeries and the dates performed.

____

____

____

Review of Systems:

Please indicate any medical problems that you currently have or had in the past.

LUNG:

Asthma	Pulmonary Embolism	Respiratory Arrest
COPD	Pneumonia	Sleep Apnea
Emphysema	Tuberculosis	

Other: ___________________________

CARDIAC:

Chest Pain/Angina	High Blood Pressure	Arrhythmia
Heart Attack	Murmur/Valve Disorder	Bleeding Problems
Peripheral Vascular Disease	Mitral Valve Prolapse	Congestive Heart Fail

NEURO:

Stroke/TIA	Multiple Sclerosis	Fibromyalgia
Peripheral Neuropathy	Cerebral Palsy	Polio
Parkinson's		

Other: ____________________________

BONE/JOINT:

Osteoarthritis	Osteomyelitis	Gout
Rheumatoid Arthritis	Ankylosing Spondylitis	Lupus

Other: _____________________________

GASTRO:

Ulcer	Diverticulitis	Hepatitis, Type _____
Acid Reflux	Irritable Bowel	Crohn's
GI Bleed	Celiac's	Ulcerative Colitis

Other: _____________________________

URINARY:

UTI	Kidney Stones	Incontinence
Kidney Failure/Dialysis	Other: __________________________	

Name:____

METABOLIC/OTHER:

Diabetes, Type ________, ______ years		Depression Anxiety
Hashimoto's Thyroiditis	Hypothyroidism	Hyperthyroidism
Grave's Disease	Sickle Cell Disease	Psoriasis
High Cholesterol	Tooth Abscess	Skin Ulcer
Alcohol/Drug Dependency	Cancer (please specify):____________________	

Other: ____

Family History: Please Indicate any significant family history and the affected member of your family (i.e. mother, paternal grandfather, etc)

COPD/Emphysema	Lupus
Heart Attack	Gout
Peripheral Neuropathy	Bowel Disease
Liver Disease	Hepatitis, Type _______
Kidney Failure	Sickle Cell Disease
Diabetes, Type _______	Stroke
Hypothyroid	High Cholesterol
Hyperthyroid High	Blood Pressure
Tuberculosis	Other Lung: _______________
Congestive Heart Failure	Other Heart: _______________
MS	Other Neuro:_______________
Parkinson's	

Cancer: (please specify) ____

Significant Trauma/Accidents: _________________________________

____

Primary Care Physician (Name, Address, Phone Number)

____

____

____

Name:____

Informed Consent:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physio-therapy on me (or the patient named below, for who whom I am legally responsible) by SG Chiropractic Health Care, PC's doctors. All these licensed Doctors of Chiropractic have my consent to treat me, who now or in the future treat me while employed by, working, or associated with, or serving as backup for SG Chiropractic Health Care, PC, including those working at the clinic or office listed or any future office or clinic.

I have had an opportunity to discuss with the doctor named below and/or with other office/clinic personnel the nature and purpose of chiropractic adjustments or other procedures. I understand that results are not guaranteed. I understand that the doctor(s) do not offer to diagnose or treat any condition or disease other than vertebral subluxation, nor do they offer advice regarding treatment prescribed by others. However, if during a chiropractic examination, abnormal or unusual findings outside the scope of chiropractic are discovered, the doctor will advise me and make the most appropriate referral.

I understand I am informed that, as in the practice of medicine, in the practice of chiropractic, there are some risks to treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the procedure(s) which the doctor feels, at the time, based upon the facts then known, is in my best interests. I understand that all adjustments are made in the open suite and that if I require private consultation with the doctor, I can arrange that with the front desk staff at any time during normal office hours.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about this consent, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present conditions and for any future condition(s) for which I seek treatment.

Patient Signature _______________________________________ Date: ________________

Doctor Signature _______________________________________ Date: ________________

Authorization to Release Medical Records:

I authorize the release of any medical information necessary to process my case and/or insurance claim(s) and certify that all insurance information given to this clinic is correct and complete.

Patient Signature _______________________________________ Date: _______________

Assignment of Benefits:

I, the undersigned, have insurance coverage _______________________________________
and assign directly to SG Chiropractic Health Care, PC, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Patient Signature_______________________________________ Date: ________________