Burgdorf Chiropractic * 7750 Merrick Road * Rome, New York 13440 * 315-336-6761

DATE: / /

PATIENT HISTORY
Welcome To Our Office !

Office I.D. #

Name: _____
Address: _____
City: _____ **ST:** _____ **Zip:** _____

Home Phone: (_____) - _____ - _____
Work Phone: (_____) - _____ - _____
Cell Phone: (_____) - _____ - _____

Date of Birth: _____/_____/_____ **Age:** _____
Height: _____ **ft.** _____ **in.** **Weight:** _____ **lbs.**
Marital Status: S M W D **Spouse:** _____

Employer: _____
Occupation: _____

Emergency Contact Person:
_____
Relation: _____
Phone: (_____) - _____ - _____

Your Email Address: (for our monthly newsletters only. It **will not** be shared).

HEALTH PROBLEMS / COMPLAINTS

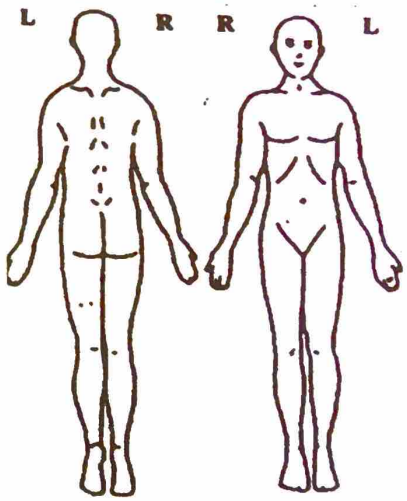
[ ] I am here for a general health evaluation [ ] I am suffering from a particular health problem(s).
What caused this problem? [ ] Auto-Accident [ ] Work-Injury [ ] Fall-Slip [ ] Overexert [ ] Gradual [ ] Unknown

Please describe your complaints:
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

What treatments or tests have you had and what results did you see? ___
_____

Have you missed work because of this? [ ] Yes [ ] No
How much and when?

Clearly mark the pain location(s)



When did this first begin? _____ **Are these problems getting worse?** [ ] Yes [ ] No
How often does it occur? [ ] Occasional [ ] Frequent [ ] Constant [ ] Varies [ ] Other _____
Describe the problem: [ ] Mild [ ] Moderate [ ] Severe [ ] Pains vary depending on activity or position._____
Character of problem? [ ] Sharp [ ] Ache [ ] Burn [ ] Numb [ ] Varies [ ] Other _____
What relieves it? [ ] Rest [ ] Drugs [ ] Ice [ ] Exercise [ ] Nothing [ ] Other _____
What aggravates it? [ ] Sitting [ ] Standing [ ] Lifting [ ] Bending [ ] Lying [ ] Driving [ ] Other_____
Do the problems interfere with..? [ ] Sleep [ ] Daily living [ ] Work ...**How?** _____

Who is your primary physician? _____ Phone # (_____)-_____-_____
When was your last physician visit? Date: _____/_____/_____ Reason: _____
Have you seen other Chiropractors? [ ] Yes [ ] No Name: _____
What results did you see?

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Drugs / Supplements / Chemicals

List ANY **over-the-counter** or **prescription** medications.

Medications	For What?	How often?

List ANY **vitamins or supplements** that you are taking.

Which of the following do you use and how much?

[ ] Tobacco _____
[ ] Coffee _____
[ ] Tea _____
[ ] Alcohol _____
[ ] Sodas _____
[ ] Sweeteners _____
[ ] Fast food _____
[ ] Junk food _____

PREGNANCY (females only)

It is often clinically necessary to take x-rays to provide proper care, but is contra-indicated if you are pregnant.

ARE YOU PREGNANT? [ ] Yes [ ] No [ ] Maybe

First day of last menstrual period _____/_____/_____

[ ] Hysterectomy [ ] Tubal Ligation [ ] Menopause

Past History

Please list previous accidents/injuries, hospitalizations:

_____

_____

Major childhood traumas: _____

_____

List past surgeries and dates: _____

_____

Broken bones: _____

Allergies: _____

Any problem history with the following areas?

Cancer	N Y	_____
Diabetes	N Y	_____
Heart	N Y	_____
Respiratory	N Y	_____
Skin	N Y	_____
Genito-Urinary	N Y	_____
Gastro-Intestine	N Y	_____
Ear, Eye, Nose	N Y	_____
HIV positive	N Y	_____

Any other particular health conditions? [ ] Yes [ ] No

Explain: _____

Family History

Age of your parents and state of health? _____

_____

If deceased, cause of death? _____

Your siblings, ages, and health? _____

_____

Your children, ages, and health? _____

_____

Additional Comments: _____

_____

Authorization and Assignment of Benefits

By my signature below, I certify that the above information is correct. I authorize Burgdorf Chiropractic, to perform an examination, order x-rays if necessary, and administer chiropractic treatment. I authorize Burgdorf Chiropractic to contact other health care providers I have to coordinate my care, and to release information to any other providers for coordination of care.

I further authorize the release of my health information to any insurance company, adjustor, or attorney as deemed necessary to process any claim for reimbursement purposes for any charges incurred at this office. I authorize and assign direct payment to Burgdorf Chiropractic / Dr. Burgdorf by any insurance company or attorney obligated to reimburse me for services rendered at this office.
I understand that I am ultimately responsible for any outstanding amounts, deductibles, or co-payments.

Patient Signature: _____ **Date:**____/____/____ **Soc.Sec.#**_____

Guardian Signature: _____ **Date:**____/____/____ **Soc.Sec.#**_____

DO NOT WRITE BELOW THIS LINE / OFFICE USE ONLY

Patient Accepted for care? [ ] Yes [ ] No [ ] Referred Reviewed By: _____ Dr. Burgdorf _____

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REVIEW OF SYSTEMS

Name: _____ **Date:** _____/_____/_____

Please Check Off All Conditions That You Have or Have Had Below

	GENERAL
	POOR SLEEP
	FATIGUE
	NO APPETITE
	WEIGHT LOSS
	WEIGHT GAIN
	INFECTIONS
	EXCESS THIRST
	FEVER / CHILLS
	ANEMIA
	NIGHT SWEATS

	DIGESTIVE
	HEARTBURN
	VOMITING
	NAUSEA
	BLOODY STOOL
	I.B.S. CRAMPS
	COLITIS
	CROHN'S
	DIARRHEA
	CONSTIPATION
	RECTAL BLOOD

	REPRODUCTIVE
	PELVIC PAIN
	PAINFUL PERIOD
	INFERTILITY
	IMPOTENCE

	NERVE SYSTEM
	STROKE
	HEADACHES
	POOR BALANCE
	DIZZINESS
	NUMB / TINGLE
	WEAKNESS
	BLACKOUTS
	SHAKING

	IMMUNE SYSTEM
	ALLERGIES
	CANCER
	AIDS / H.I.V.

	LYMPH * BLOOD
	GLAND SWELL
	EASY BLEEDER
	SLOW HEALER

	ENDOCRINE
	DIABETES
	THYROID
	HOT FLASHES

	PSYCHIATRIC
	ANXIETY
	DEPRESSION
	MENTAL ILLNESS
	HALLUCINATE

	HEAD - E.E.N.T.
	SINUS PAIN
	BLURRED VISION
	EYE PAIN
	HEARING LOSS
	RINGING EARS
	SWALLOW PAIN
	CONGEST NOSE
	SORE THROATS

	MUSCLE * JOINT
	SWOLLEN JOINT
	STIFF JOINT
	STIFF MUSCLES
	ACHEY MUSCLE
	STIFF NECK
	BACK PAIN
	PAIN WALKING

	SKIN / BREAST
	RASHES
	MOLE PROBLEM
	SKIN CANCER
	HAIR DANDRUFF
	ECZEMA
	PSORIASIS
	BREAST LUMPS
	BREAST PAINS
	NIPPLE FLUID

	HEART
	HI BLOOD PRES
	LO BLOOD PRES
	CHEST PAIN
	PALPITATIONS
	HEAVY CHEST
	ANKLES SWELL

	LUNGS
	COUGH
	SHORT BREATH
	ASTHMA
	SPIT BLOOD
	SLEEP APNEA

	URINARY
	EXCESS URINE
	URINE PAIN
	BLOOD URINE
	LEAKY BLADDER

Reviewed by Dr. Burgdorf

_____/_____/_____

Comments:

_____

_____

_____

_____

_____

Patient Signature: _____ **Date:** _____/_____/_____

NOTICE OF PRIVACY

Burgdorf Chiropractic * 7750 Merrick Road * Rome, N.Y. 13440 * 315-336-6761

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and terms of this notice at any time. Provided that the changes are permitted by law.
2. Make changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided on this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services.

We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

PRIVACY PRACTICE ACKNOWLEDGEMENT

I have read the Notice of Privacy and I have been provided an opportunity to review it.

Patient Signature: _____ **Date:**____/____/____