Owego Chiropractic, P.C.
115 Temple Street, Owego NY 13827
(607)687-3800

Patient Information

Patient Name

Last_____First_____Middle Initial_____
Name you prefer to be called by (nickname)_____
Gender M F (circle one) Date of Birth____/____/_____Age_____SS#_____ _____ _____
Home Address_____
City_____State_____Zip_____
Home Phone_____Work Phone_____
Cell Phone_____Cell Phone Carrier_____
Email (home)_____Email (work)_____
Preferred method(s) of contact: (check all that apply)
Email (home)_____(work)_____ Phone (home)_____(work)_____(cell)_____
Would you want to be contacted by Text?_____ or receive emails from us?_____
Employer_____Occupation_____
Employer Address_____
Marital Status: married_____single_____divorced_____separated_____widowed_____
Spouse Name:_____

Who Referred you to this office_____

Emergency Contact

Name_____Relation to Patient_____
Number(s)where can be reached_____

If you are acting on above patient's behalf please fill out:

Last name_____First_____Middle Initial_____
Relationship to patient_____
Gender M F Date of Birth____/____/_____SS#____ ____ _____
Home Address_____
City_____State_____Zip_____
Home Phone_____Work Phone_____
Cell Phone_____Email_____
Employer_____Occupation_____
Employer Address_____

My Certification

I certify that the above information is correct and I request services.

X_____ _____
Signature of patient or person acting on patient's behalf Date

My Privacy

I have received a copy of the Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: 1. Conduct, plan and direct my treatment and follow-up among healthcare providers who may be directly and indirectly involved in providing my treatment; 2. Obtain payment from third-party payers; 3. Conduct normal healthcare operations such as quality assessments and accreditation.

X_____ _____
Signature of patient or person acting on patient's behalf Date

Insurance Information

My Responsibility

I understand that it is my personal responsibility to verify the chiropractic benefits of my health care coverage before I visit this office.
I also understand that I am personally responsible for all services not paid for by my insurance. All balances unpaid after 60 days will be charged at a rate of 18% annually, 1.5% per month.

Patient Information

Last Name_____First_____Middle Initial_____
Relationship to Insured ◘Self ◘Spouse ◘Child ◘other_____

Primary Insurance Information

Policy Holder Information:
Last_____First_____Middle Initial_____
Date of Birth_____/_____/_____Employer_____
Address (if different from patient)_____
_____
Name of Insurance Provider_____
ID #_____Group #_____
Effective Date____/____/_____
Deductible? (calendar / fiscal) $_____Met? ◘Yes ◘No
Co-pay? ◘Yes ◘No If Yes, Amount $_____
Visit limits per year? (calendar / fiscal) # per year_____Met? ◘Yes ◘No

Secondary Insurance Information (if applicable)

Policy Holder Information:
Last_____First_____Middle Initial_____
Date of Birth_____/_____/_____Employer_____
Address (if different from patient)_____
_____
Name of Insurance Provider_____
ID #_____Group #_____
Effective Date____/____/_____
Deductible? (calendar / fiscal) $_____Met? ◘Yes ◘No
Co-pay? ◘Yes ◘No If Yes, Amount $_____
Visit limits per year? (calendar / fiscal) # per year_____Met? ◘Yes ◘No

My Authorization

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the undersigned physician or supplier for services rendered.

X_____ _____
Signature of patient or person acting on patient's behalf Date

Patient Name_____

Tell us why you are visiting our office today:

Present symptoms and/or illnesses_____

_____

_____

_____

_____

List your four major health concerns in order of importance:

1._____Date of onset_____
2._____Date of onset_____
3._____Date of onset_____
4._____Date of onset_____

Clinical Record

Check all the following symptoms which you have now, or have had problems with in the past:

E.E.N.T.
____Asthma
____Crossed Eyes
____Deafness
____Dental Decay
____Earache
____Ear discharges
____Ear noises
____Enlarged glands
____Enlarged Thyroid
____Eye pain
____Failing vision
____Far sightedness
____Frequent colds
____Gum trouble
____Hay fever
____Hoarseness
____Nasal drainage
____Nasal obstruction
____Near sightedness
____Nose bleeds
____Sinus infection
____Sore throat
____Tonsillitis

Cardiovascular
____Hardening of arteries
____High blood pressure
____Low blood pressure
____Pain over heart
____Paralytic stroke
____Poor circulation
____Previous heart stroke
____Rapid beating heart
____Slow beating heart
____Swelling of ankles

Genitourinary Symptoms
____Bed wetting
____Blood in urine
____Frequent urination
____Inability to control urine
____Kidney infection
____Painful urination
____Prostate trouble
____Pus in urine

General Symptoms
____Allergic
____Allergy
____Chills
____Convulsions
____Dizziness
____Fainting
____Fatigue
____Fever
____Headache
____Loss of sleep
____Loss of weight
____Migraine
____Nervousness
____Neuralgia
____Numbness or pain in arms, hands, or legs
____Obesity
____Sweats
____Tension
____Wheezing

Skin
____Bruises easily
____Dryness
____Eczema
____Hives or allergy
____Itching
____Psoriasis
____Sensitive skin
____Skin eruptions
____Varicose veins

For Women Only
____Congested in breast
____Excessive flow
____Hot flashes
____Infertility
____Irregular cycle
____Lumps in breast
____Menopausal symptoms
____Painful menstrual periods
____Premenstrual headache
____Previous miscarriage
____Vaginal discharge

Gastrointestinal Symptoms
____Belching or gas
____Colitis
____Colon trouble
____Constipation
____Diarrhea
____Distension of abdomen
____Difficult digestion
____Excessive hunger
____Hemorrhoids (piles)
____Gall Bladder trouble
____Jaundice
____Liver trouble
____Nausea
____Pain over stomach
____Poor appetite
____Vomiting
____Vomiting of blood

Muscle & Joint Symptoms
____Arthritis
____Back ache
____Back spasms
____Difficulty walking
____Disc displacement
____Faulty posture
____Foot trouble
____Hernia
____Muscle spasms
____Pain between shoulders
____Pain in neck
____Painful joints
____Painful tailbone
____Sciatica
____Spinal curvature
____Stiff neck
____Swollen joint
____Tremors

Respiratory
____Chest pain
____Chronic cough
____Difficulty breathing
____Spitting up blood
____Spitting up phlegm

Personal History

Patient Name_____

Have you had any of the following diseases? Please circle.

Alcoholism	Chicken Pox	Goiter	Measles	Pneumonia
Anemia	Diabetes	Heart Disease	Mental Disorder	Polio
Appendicitis	Eczema	Influenza	Mumps	Rheumatic Fever
Arthritis	Epilepsy	Lumbago	Pleurisy	Tuberculosis

Have you been hospitalized?_____

_____

Have you had any surgeries?_____

_____

Accident or falls? Knocked unconscious or stunned? (describe fully)_____

_____

Fractures or dislocations_____

_____

List any medications you take_____

_____

_____

How many hours do you generally sleep?_____

Do you drink coffee?____Tea?____Alcohol?____Use recreational drugs?____Exercise?____

Family History

Please tell us about your family history. Circle or check everything that applies. If someone is deceased, please circle "D" ("L" for still living) and write in the cause of death.

		Heart Disease	Stroke	Cancer	Diabetes	Rheumatoid Arthritis	Multiple Sclerosis	Lung Disease	Bone Disease
Father	L D Cause:								
Mother	L D Cause:								
Grandfather (Paternal)	L D Cause:								
Grandmother (Paternal)	L D Cause:								
Grandfather (Maternal)	L D Cause:								
Grandmother (Maternal)	L D Cause:								
Sibling M F	L D Cause:								
Sibling M F	L D Cause:								
Child M F	L D Cause:								
Child M F	L D Cause:								

Pain Scale

Patient Name_____

Circle the number that best describes the question being asked.

1. What is the level of your pain **right now?**

No Pain___1___2___3___4___5___6___7___8___9___10___Worst possible pain

2. What is your **typical** or **average** pain?

No Pain___1___2___3___4___5___6___7___8___9___10___Worst possible pain

3. What is your level of pain **at its best?**
(How close to "O" does your pain get when it bothers you **least?**)

No Pain___1___2___3___4___5___6___7___8___9___10___Worst possible pain

4. What is your pain level **at its worst?**

No Pain___1___2___3___4___5___6___7___8___9___10___Worst possible pain

Pain Drawing

Circle the location of your pain on the body outlines below. Use the initials to signify your specific symptoms.

A – Ache **B – Burning** **N – Numbness**
P – Pins & Needles **S-Stabbing** **O – Other**