Family Chiropractic Prevention Center
7550 Oswego Road
Liverpool, NY 13090
315.453.4040
www.WeCare4Families.com

Date: _____/_____/_____

Name: (FIRST)_____(MI) _____(LAST) _____Circle: MALE / FEMALE

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

E-mail (please print) _____

Birth Date: _____/_____/_____

REQUIRED TO BE SEEN AT THIS OFFICE SS #: _____-_____-_____ **(IF UNDER 18 PARENT/GURADIAN # REQUIRED)**

Address: _____City: _____State: _____Zip: _____

Occupation: _____Employer: _____

Marital Status: Married Widow Divorced Single Spouse / Significant Others Name: _____

Name of Children: _____

Many patients are referred to the office by friends, family, or other doctors. Who or what made you decide to visit us today?

_____

Name of Insured (person who maintains your insurance benefit): _____

Insured Date of Birth: _____/_____/_____Insured Employer: _____

Science tells us your spine should be cared for regularly. How often do you get a chiropractic adjustment?

FREQUENTLY ONLY WHEN HURT 1 X A WEEK NEVER

When was your last spinal examination including x-rays? Date: _____ NEVER

Name of your most recent Chiropractor_____

Do you know if you have a spinal curvature, spinal arthritis, or inherited spinal problem? YES NO

Over time spinal misalignments will cause arthritis and degeneration which results in grinding or cracking to be heard when you move your neck or back. Do you hear these sounds when you move your head or neck? YES NO

If your spine is out of alignment for a long time it can make you feel like you need to twist, stretch, crack or pop your back or neck. Are you forcibly doing this to your neck or back? YES NO

Poor posture leads to poor health and early death. Please rate your posture? POOR FAIR GOOD EXCELLENT

Spinal health is vitally important to ensure a healthy pregnancy. Is there a chance you are pregnant? YES NO

Improper sleeping positions can cause spinal damage, what sleeping position do you sleep in?
BACK STOMACH RIGHT SIDE LEFT SIDE

Please list any surgeries you've had:

Type of Surgery	Date

Is this a current work or auto related accident? YES NO

Are you currently represented by an attorney? YES NO

Patient name:_____ Date:_____

Previous Injury or trauma (Ie. Auto Accident, major slips & falls) _____

_____

Have you ever broken any bones? Which? _____

Any allergies: _____

Prescription medications can cause various side effects that hide the severity of health problems and hinder the body's ability to heal. Please indicate below the prescription medications you are currently taking? (use back if necessary):

Name of Medication/including OTC	Dose/Frequency	Reason for Taking

Please list any vitamins/supplements you take:

Vitamin/Supplement	Dose/Frequency	Reason for Taking

COVID Vaccines:

How many COVID vaccination/boosters have you received:_____ What was the date of the last booster:_____

Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Heart disease □ Neurological diseases □ Adopted/Unknown □ Cardiac disease below age 40

□ Psychiatric disease □ Diabetes □ Other _____ □ None of the above

Deaths in immediate family:

Cause of parents' or siblings' death Age at death

_____

_____

_____

_____

Patient name:_____ Date:_____

Do you smoke cigarettes? NO YES how many per day _____ Per week_____ for how many years_____

Do you use marijuana? NO YES

Do you use illegal drugs? NO YES if yes what kind:_____how often:_____

What is your caffeine intake (please circle)

NO caffeine 1- 8 oz. cup/day 2-4 8 ox. Cups/day 5 or more 8 oz. cups/day

What is your alcohol intake (please circle)

NO Alcohol social drinker light drinker moderate drinker heavy drinker struggles w/alcohol

Tell us about your work habits (please circle all that apply)

Full-time	part-time	Retired	Disabled	unemployed	
0-20 hours	20-40 hours	40-50 hours	50-60 hours	60-70 hours	over 70 hours
Heavy labor	moderate labor	light labor			
Telephone	computer	mostly standing	mostly sitting	mostly walking	
Stressful	relaxed	enjoyable	difficult		

Tell us about your stress: (please circle all that apply)

Daily	Weekly	Monthly	occasionally	constantly					
Level of stress:	1	2	3	4	5	6	7	8	9	10
Type of stress:	work	home	emotional	physical	chemical					

Tell us about the kinds of exercise that participate in: (please circle all that apply)

Almost nothing	weight training	strength training w/a trainer	physical therapy	walking running
Cycling	hiking	climbing	stretching	yoga
Pilates	kickboxing	mountain climbing	skiing	snowboarding
Baseball	basketball	football	soccer	tennis
Racquetball	Lacrosse	Gym machines	bowling	crossfit
Martial Arts/MMA	volleyball	golf	fishing	marathon training
Boating	Marching band	body building	snow mobiling	swimming

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____□ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems
□ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other _____ □ None of the above

Patient name:_____ Date:_____

Have you had any of the following **neurological (nerve-related)** issues?

□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell
□ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other _____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Other _____ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here? _____

Patient name:_____ Date:_____

Please indicate the symptoms that brought you in today – Start with the issue of greatest significance --

Symptom 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? _____
  - How did the symptom begin? _____

- What makes the symptom worse? (circle all that apply):
  - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe):
    _____

- What makes the symptom better? (circle all that apply):
  - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____

- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): _____

- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____

- Is the symptom worse at certain times of the day or night? (please circle)
  - No difference Morning Afternoon Evening Night Other _____

- Have you received treatment for this condition and episode prior to today's visit?
  - No
  - Anti-inflammatory meds
  - Pain medication
  - Muscle relaxers
  - Trigger point injections
  - Cortisone injections
  - Surgery
  - Massage
  - Physical Therapy
  - Chiropractic
  - Other _____

Patient name:_____ Date:_____

Please indicate the symptoms that brought you in today: --Secondary complaint

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? _____
  - How did the symptom begin? _____

- What makes the symptom worse? (circle all that apply):
  - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe):
    _____

- What makes the symptom better? (circle all that apply):
  - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____

- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): _____

- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____

- Is the symptom worse at certain times of the day or night? (please circle)
  - No difference Morning Afternoon Evening Night Other _____

- Have you received treatment for this condition and episode prior to today's visit?
  - No
  - Anti-inflammatory meds
  - Pain medication
  - Muscle relaxers
  - Trigger point injections
  - Cortisone injections
  - Surgery
  - Massage
  - Physical Therapy
  - Chiropractic
  - Other _____

Patient name:_____ Date:_____

Please indicate the symptoms that brought you in today: --tertiary complaint --

Symptom 3 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? _____
  - How did the symptom begin? _____

- What makes the symptom worse? (circle all that apply):
  - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe):
    _____

- What makes the symptom better? (circle all that apply):
  - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____

- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): _____

- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____

- Is the symptom worse at certain times of the day or night? (please circle)
  - No difference Morning Afternoon Evening Night Other _____

- Have you received treatment for this condition and episode prior to today's visit?
  - No
  - Anti-inflammatory meds
  - Pain medication
  - Muscle relaxers
  - Trigger point injections
  - Cortisone injections
  - Surgery
  - Massage
  - Physical Therapy
  - Chiropractic
  - Other _____

Patient name:_____ Date:_____

Please indicate the symptoms that brought you in today: --next complaint --

Symptom 4 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? _____
  - How did the symptom begin? _____

- What makes the symptom worse? (circle all that apply):
  - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe):
    _____

- What makes the symptom better? (circle all that apply):
  - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____

- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): _____

- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____

- Is the symptom worse at certain times of the day or night? (please circle)
  - No difference Morning Afternoon Evening Night Other _____

- Have you received treatment for this condition and episode prior to today's visit?
  - No
  - Anti-inflammatory meds
  - Pain medication
  - Muscle relaxers
  - Trigger point injections
  - Cortisone injections
  - Surgery
  - Massage
  - Physical Therapy
  - Chiropractic
  - Other _____

If the doctor identifies your spine to be misaligned, are you committed to following the recommendations to correct your problem completely?

YES NO

What are your treatment and health goals? (Please circle all that apply)

Corrective care	relief care	relief of symptoms	return to pre-injury status
Preventative care	increased overall health	improved nutrition	healthy diet
Loss of excess body fat	strengthening	look and feel better	

What are 3 things that your symptoms are preventing you from doing that you would like to be able to do in the next year?

1. _____

2. _____

3. _____

As you view the activities, please circle the area of pain the corresponds to that activity:

Housework **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Shopping **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Driving **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Social outings **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Care of pets **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Child care **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Dressing **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Climbing stairs **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Walking **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Shoveling **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Computer work **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Yard work **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Sex **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Sitting **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Standing **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Getting out of tub **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Sleep **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Mood **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
In/out of car **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Exercising **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
In/out of bed **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Paying attention **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Bowel movements **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Energy level **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Sitting to standing **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs
Putting shoes on **is affected because of my:** headache - neck/shoulder - mid back - low back – sacrum – pelvis - arms and legs

Thank you for the opportunity to better serve you.

- **We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and practice member.**
- **Our policy requires payment in full for all services rendered at the time of visit unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account, there will be a $5.00 late charge or a 1.5% per month late fee whichever is greater.**
- **We will make every attempt to get your insurance to approve your care. We will keep you up to date on the status of your coverage. Often it is difficult to get your insurance to acknowledge the practice member's complete health care needs over their own financial concerns. However, we will not compromise the quality of the health care we provide. Our responsibility is to you, our practice member, first and foremost.**
- **The thermal subluxation scan is not reimbursed by your insurance carrier. The $35.00 charge is the patient's responsibility. There will be a $50.00 charge in addition to your normal co-pay for all emergency visits.**
- **I consent to event photos taken in the office being used in the office, on Family Chiropractic's website and Facebook.**
- **I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization to release any information required to process any insurance claims.**
- **I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.**
- **Any balance that is left unpaid by your insurance company is your sole responsibility.**

Signature (Practice Member/Guardian) _____ Date: _____/_____/_____

I acknowledge that I have been given the opportunity to read and/or receive a copy of Family Chiropractic Prevention Center's Privacy notice and discuss any questions I may have regarding HIPPA with the doctor and/or the staff.

Leave appointment messages on:	Leave other medical/insurance info on:	Special Services, Events, New Health Info, website/Facebook photos on:
ANY OF THE BELOW ☐	**ANY OF THE BELOW** ☐	**ANY OF THE BELOW** ☐
Answering machine	Answering machine	Answering machine
Cell phone or text message	Cell phone or text message	Cell phone or text message
Office voice mail	Office voice mail	Office voice mail
Email	Email	Email
w/Person(s) listed below	w/Person(s) listed below	w/Person(s) listed below

Any person(s) at home phone #: Y / N

Person(s) authorized to discuss the above:

_____ Relationship_____

_____ Relationship_____

Signature (Practice Member/Guardian) _____ Date: _____/_____/_____

I consent to have the Practice use and disclose my protected health information for treatment, and health care operations purposes, and for such other purposes that are permitted under HIPPA

Signature (Practice Member/Guardian) _____ Date: _____/_____/_____

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working for the same objective. It is important that each patient understands both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science, philosophy and art which concerns itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors we understand that health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes an unhealthy change to nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific application of force to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are done by hand where the doctor will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position.

If at the beginning or during the course of care we encounter a non-chiropractic or unusual findings, we will advise you of those findings and recommend some further testing or refer you out to another health care provider.

Chiropractic care has been proven to be very safe and effective. It is not unusual, however, to be sore after your first few corrective adjustments. Although rare it is possible to suffer from other side effects, i.e. muscle spasms, stiffness, rib fracture, headache, dizziness and stroke.

All questions regarding the doctor's objective to my care in this office has been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____

Print Name Signature Date

Consent to evaluate and adjust a minor child

I,_____ being the parent or legal guardian _____ of have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am **not pregnant,** and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual cycle:_____

_____

Signature Date

Family Chiropractic Prevention Center

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