Finger Lakes Chiropractic of Skaneateles
Confidential Patient Health Record

NAME _____ MI_____ **TODAY'S DATE** ___/___/___

Male ☐ Female ☐ **DOB** ___/___/___AGE ____HEIGHT_____ WEIGHT _____BLOOD PRESSURE:_____

HOME ADDRESS _____
STREET CITY STATE ZIP

PHONE (H) _____ **(C)** _____ **(W)**_____**E-MAIL**_____

How did you hear about our office?_____

EMPLOYER _____OCCUPATION _____

WORK ADDRESS _____
STREET CITY STATE ZIP

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er) How many children? ____ Ages_____

SPOUSE _____ OCCUPATION _____

EMPLOYER _____ PHONE (W) _____

In the event of an emergency, whom shall we contact? _____

RELATION _____ Home/Cell Phone _____ Office Phone _____

*****CMS requires providers to report both race and ethnicity. Please answer the three questions below. *****

RACE (check one): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White (Caucasian) / Native ☐ Hawaiian or Pacific Islander ☐ Other ☐ I Decline to Answer

ETHNICITY (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I Decline to Answer

SMOKING STATUS (check one): ☐ Every Day Smoker ☐ Occasional Smoker ☐ Former Smoker ☐ Never Smoked

INSURANCE INFORMATION: ***Please present your insurance card to the receptionist to make a copy.***

HEALTH INSURANCE CARRIER (company) _____ID#_____

Policy holder _____Policy Holder's DOB**:** ___/___/___ Relation_____

Is condition due to an accident? ☐Yes ☐No Type of accident: ☐Auto ☐Work ☐Home

Date of Accident _____For an Auto or Work injury please provide your SS#_____

To whom have you made a report of your accident? ☐Auto Insurance ☐ Employer ☐Worker Comp. ☐Other

AUTO OR WORKERS COMPENSATION INSURANCE INFORMATION:

Carrier name:_____Address:_____

Adjuster Name: _____Phone#:_____Claim#:_____

Attorney Name (if applicable)_____

HEALTH HISTORY

List present complaints:

1. _____ For how long? _____

2. _____ For how long? _____

3. _____ For how long? _____

Remarks: _____

_____

List other doctors consulted for this condition(s):

Name _____ Address _____

Diagnosis _____

Treatment _____

Results _____

Name _____ Address _____

Diagnosis _____

Treatment _____

Results _____

Last visit to a medical doctor and why ___/___/___ _____

_____

What surgeries have you had?

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Remarks _____

_____

Any serious accidents or falls?

1. _____ When _____

2. _____ When _____

3. _____ When _____

Remarks _____

_____

Any broken bones?

1. _____ When _____
2. _____ When _____
3. _____ When _____

Remarks _____

_____

Check any of the following you have or have had in the past five years:

General Symptoms

- ☐ Headache
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Fainting
- ☐ Dizziness
- ☐ Convulsions
- ☐ Loss of sleep
- ☐ Fatigue
- ☐ Nervousness
- ☐ Loss of weight
- ☐ Numbness or pain in arms, hands, or legs

Eyes, Ears, Nose, Throat

- ☐ Failing vision
- ☐ Near sightedness
- ☐ Crossed eyes
- ☐ Eye Pain
- ☐ Deafness
- ☐ Ear ache
- ☐ Ear noises
- ☐ Ear discharge
- ☐ Nose Bleeds
- ☐ Nasal obstruction
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Hay fever
- ☐ Asthma
- ☐ Dental Decay
- ☐ Gum Trouble
- ☐ Frequent colds
- ☐ Enlarged Thyroid
- ☐ Tonsillitis
- ☐ Sinus infection
- ☐ Nasal drainage
- ☐ Enlarged glands

Skin

- ☐ Skin eruptions
- ☐ Itching
- ☐ Bruises easily
- ☐ Dryness
- ☐ Boils
- ☐ Chills
- ☐ Varicose veins
- ☐ Sensitive skin
- ☐ Hives or allergies

Respiratory

- ☐ Chronic cough
- ☐ Spitting up phlegm
- ☐ Spitting up blood
- ☐ Chest Pain
- ☐ Difficult breathing

Cardio-vascular

- ☐ Rapid beating heart
- ☐ Slow beating heart
- ☐ High Blood pressure
- ☐ Low blood pressure
- ☐ Pain over Heart
- ☐ Previous heart stroke
- ☐ Hardening of arteries
- ☐ Swelling of ankles
- ☐ Poor circulation
- ☐ Paralytic stroke

Muscle and joint

- ☐ Stiff neck
- ☐ Back ache
- ☐ Swollen joints
- ☐ Tremors
- ☐ Painful tailbone
- ☐ Foot trouble
- ☐ Pain between shoulders
- ☐ Hernia
- ☐ Spinal curvature
- ☐ Faulty posture

Genitourinary

- ☐ Frequent urination
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Pus in urine
- ☐ Kidney infection or stones
- ☐ Bed wetting
- ☐ Inability to control urine
- ☐ Prostrate trouble

Gastrointestinal

- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Belching or gas
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting of blood
- ☐ Pain over stomach
- ☐ Distention of abdomen
- ☐ Constipation
- ☐ Diarrhea
- ☐ Colon trouble
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Liver trouble
- ☐ Gall bladder trouble
- ☐ Jaundice
- ☐ Colitis

Female

- ☐ Painful menstrual periods
- ☐ Excessive flow
- ☐ Hot flashes
- ☐ Irregular cycle
- ☐ Cramps or back ache
- ☐ Previous miscarriage
- ☐ Vaginal discharge
- ☐ Congested breast
- ☐ Lumps in breast
- ☐ Menopausal symptoms

Are you taking any medications and/or diet supplements?

What _____ Frequency _____ Doctor _____

What _____ Frequency _____ Doctor _____

What _____ Frequency _____ Doctor _____

What _____ Frequency _____ Doctor _____

Remarks _____

Do you have any medication allergies?

Medication name_____Reaction_____Onset Date_____

Medication name_____Reaction_____Onset Date_____

Medication name_____Reaction_____Onset Date_____

List any conditions you have been or are being treated for (i.e. Pneumonia, Rheumatoid Arthritis, Stroke, Heart Disease, Diabetes etc….) _____

_____

Are there any other conditions that you experience that you have not mentioned?

_____

_____

Thank you for taking the time to complete this important form. Your honest answers will better help us determine the best treatment plan for 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 patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office manager. If discrepancies arise with your insurance company we will certainly help rectify the situation but you are ultimately responsible for any bills.
- I authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.
- I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature _____ Date ___/___/___

Guardian or Spouse's
Signature Authorizing Care _____ Date ___/___/___