Schuyler Creek
CHIROPRACTIC CENTER

New Patient Health History

PATIENT INFORMATION

Patient's Last Name:	Patient's First Name:	Middle Init.:	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital status: ☐Single ☐Mar ☐Div. ☐Sep. ☐Widow

Cell Phone #: ( )	Home Phone #: ( )	E-mail Address:	Birth date:	Age:	Sex: ☐ M ☐ F

Street Address:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer Phone #: ( )

Referred to office by:	Have you ever been to a chiropractor before? ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION

Emergency Contact Person:	Relationship to Patient:	Best Phone #: ( )	Alternate Phone #: ( )

CHIEF COMPLAINT

What is your reason for coming into our office?	When did this occurrence begin?

Have you experienced this pain before? ☐ Yes ☐ No ☐ This has been a chronic problem	If Yes, when?	Since it began, is this problem: ☐ better ☐ worse ☐ about the same

If you are experiencing pain is it: ☐ sharp ☐ dull ☐ achy ☐ constant ☐ comes and goes ☐ radiating down arm(s) ☐ radiating down leg(s)

Does your pain interfere with: ☐ work ☐ sleep ☐ walking ☐ sitting ☐ standing ☐ hobbies ☐ leisurely activities ☐ housework

On a scale of 1-10 (with 10 being the worst), please rate your pain level right now: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What makes your complaint better?	What makes your complaint worse?

Please check all symptoms you have or are experiencing, even if it does not seem related to your current problem.

☐ Headache	☐ Upper Back Stiffness	☐ Fainting	☐ Fever
☐ Neck Stiffness	☐ Mid Back Stiffness	☐ Chest Pain	☐ Easily Fatigued
☐ Eyes Sensitive to Light	☐ Pins and Needles in Arms	☐ Shortness of Breath	☐ Other
☐ Ringing in Ears	☐ R / L Shoulder Pain	☐ Heart Palpitations	•
☐ Loss of Balance	☐ R / L Arm Pain	☐ Nervousness	•
☐ Loss of Smell	☐ Cold Hands	☐ Irritability	Please specify location of:
☐ Loss of Taste	☐ Lower Back Stiffness	☐ Nausea	Swelling
☐ Vision Problems	☐ Pins and Needles in Legs	☐ Vomiting	Bleeding
☐ Memory Loss	☐ R / L Leg Pain	☐ Diarrhea	Bruising
☐ Dizziness	☐ Cold Feet	☐ Constipation	Irritation
☐ Confusion	☐ Itchy/Burning Feet	☐ Excess Perspiration	

HEALTH HISTORY

PHYSICAL

Have you sought care elsewhere for your condition? ☐ Yes ☐ No	Who is your primary care physician?

Please list any ***significant health conditions*** you have experienced in your life?

Please list any ***significant injuries*** you have experienced in your life?

Have you ever had any ***surgeries***? ☐ Yes ☐ No If Yes, what?

Have you ever had any ***broken bones***? ☐ Yes ☐ No If Yes, what?

Have you had any x-rays or other imaging done within the past 12 months? ☐ Yes ☐ No If Yes, when?

CHEMICAL

Do you have any ***known allergies***? ☐ Yes ☐ No If Yes, what?

Please list any ***medications or supplements*** you are currently taking and why?

Please describe a typical day's meals.

Breakfast	Lunch	Dinner

Do/did you smoke? ☐ Yes ☐ No	Do/did you drink alcohol? ☐ Yes ☐ No

EMOTIONAL

What is your current stress level on a scale of 1-10 (10 being high stress)? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What causes you the most stress in your life?

What do you do for stress relief?

How often do you exercise?	Do you have difficulty sleeping? ☐ Yes ☐ No How many hours?
What do you do for a living?	What are your job duties?

If the doctor can make any recommendations your overall health and well-being, would you be interested? ☐ Yes ☐ No

Are you interested in wellness chiropractic care? ☐ Yes ☐ No

ASSIGNMENT AND RELEASE

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Schuyler Creek Chiropractic Center or my insurance company to release any information required to process my claims.

Patient/Guardian signature	***Date***

781 Hudson Avenue
Stillwater NY 12170

Dr. Kelli Patenaude, CACCP
Dr. Brady Patenaude

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Schuylercreekchiro.com

Schuyler Creek
CHIROPRACTIC CENTER

INFORMED CONSENT FOR TREATMENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fees or court costs required to collect my bill.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not mutually acceptable, the doctors will refer you to another provider who we feel can further assist you.

Chiropractic, as well as many other types of health care, is associated with potential risks in the delivery of treatment. Therefore it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Specific Risk Possibilities Associated with Chiropractic Care:

Soreness- Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you feel experience soreness or discomfort.

Soft Tissue Injury- Occasionally chiropractic treatment may aggravate a previous disc injury, or cause minor joint, ligament, tendon, muscle, or other soft tissue injury.

Rib Injury- Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

If you have any questions concerning the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

_____ _____

Patient Signature Date

_____ _____

Parent/Legal Guardian Signature Date

Schuyler Creek
CHIROPRACTIC CENTER

Patient Acknowledgement of Receipt of SCCC's Notice of Privacy Practices

By signing below, I acknowledge receiving a copy of SCCC's Notice of Privacy Practices, dated 09/23/2013.

_____ _____
Patient's Name Date of Birth

_____ _____
Signature of Patient or Personal Representative* Date

*If signed by a Personal Representative, the following information must also be included:

_____
Name of Personal Representative

_____
Description of the Personal Representative's Authority to Act on Patient's Behalf