

Welcome

ABOUT YOU

Today's Date: _____ File #: _____

Name: _____

What you Prefer To Be Called: _____ Male Female

Birth date: ___/___/___ Age: _____ SS#: _____

Home Address: _____

City _____ State _____ Zip _____

Home Phone#: _____

Other Phone#: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

City _____ State _____ Zip _____

Occupation: _____ Work Phone #: _____

Marital Status: Single Married Divorced Separated Widowed

Spouse's Name: _____

INSURANCE INFO

Company Name: _____

Address: _____

Phone #: _____

Insured's SS# : _____

Group # (Plan, Local or Policy #): _____

Primary care Physician: _____

City _____ State _____ Zip _____

Insured's Name: _____

Relation: _____ Date of Birth ___/___/___

Insured's Employer: _____
Please inform front desk of 2nd Insurance source.

IN EVENT OF EMERGENCY

Who should we contact? _____

Relation: _____

Home Phone #: _____

Work Phone #: _____

REASON FOR VISIT

Have you ever been treated by a chiropractor before? Yes No

If so, please explain: _____

The reason for this visit is a result of (*Please Circle*): work, sports, auto, trauma or chronic

(*Explain what happened*): _____

Please describe the pain & it's location: _____

When did condition begin? _____

Is this condition getting worse? Yes No Constant Comes and goes

Is this condition interfering with you (*Please Circle*): work, sleep, or daily routine

If so, please explain: _____

Have you had this or similar conditions in the past? Yes No

If so, please explain: _____

Have you been treated by a Medical Physician for this condition? Yes No

If so, where? _____

- We invite you to discuss with us any questions regarding our services. The best health services are base on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time 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 any expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also 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.






Signature _____ Date _____

PAIN CHART

About you	
Name: _____	File # _____
Please describe your condition: _____ _____	
Signature: _____	Date: ___/___/___

SHOW US WHERE IT HURTS

Please mark **area(s)** of injury or discomfort as shown below in the example.

	Numbness -----	Pins & Needles OOOOO	Burning AAAAA	Aching XXXXX	Stabbing ●●●●●
					
Example	Right	Front	Back	Left	

Indicate the degree of pain using a scale of 1 (discomfort) to 10 (extreme pain).



DOCTOR'S NOTES

THIS IS A CONFIDENTIAL HEALTH REPORT

NAME _____ (last) _____ (first) _____ (middle) _____ Date _____

HEIGHT _____ WEIGHT _____

CHILDREN (list ages & sex) _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

**OCCASIONAL
FREQUENT**

- GENERAL**
- Allergy (list below)*
- Convulsions
- Dizziness or fainting
- Headache
- Neuralgia
- Numbness
- MUSCLE**
- Arthritis
- Bursitis
- Foot trouble
- Low back pain or stiffness
- Pain between shoulders
- Sciatica
- Swollen joints
- Pain, numbness or Cramps**
- Shoulders
- Arms
- Elbows
- Hands
- Hips
- Legs
- Knees
- Feet

- GASTRO-INTESTINAL**
- Colon trouble
- Constipation
- Diarrhea
- Difficult digesting
- Gall bladder trouble
- Hemorrhoids
- Liver trouble
- Pain over stomach
- EYES, EARS, NOSE & THROAT**
- Asthma
- Colds
- Deafness
- Earache
- Ear discharge
- Ear noise
- Eye pain
- Nasal obstruction
- Sinus infection
- CARDIO-VASCULAR**
- Hardening of the arteries
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Rapid heart beat
- Swelling of ankles

- RESPIRATORY**
- Chest pain
- Chronic cough
- Difficult breathing
- Spitting up blood
- Spitting up phlegm
- Wheezing
- SKIN**
- Bruise easily
- Dryness
- Skin eruptions (rash)
- Varicose veins
- GENITO-URINARY**
- Bed-wetting
- Blood in urine
- Frequent urination
- Inability to control kidneys
- Kidney infection or stones
- Painful urination
- Prostate trouble
- Pus in urine
- FOR WOMEN ONLY**
- Congested breasts
- Cramps or backache
- Excessive menstrual flow
- Hot flashes
- Irregular cycle
- Lumps in breast
- Menopausal symptoms
- Painful menstration
- Vaginal discharge

- DATE OF LAST: (Approx.)**
- _____ Physical examination
- _____ Blood test
- _____ Chest x-ray
- _____ Spinal x-ray
- _____ Dental x-ray
- _____ Urine test

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|-------------|
| NONE | LIGHT | MODERATE | HEAVY | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Alcohol |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Coffee |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tobacco |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Drugs |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Exercise |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Soft Drinks |

- HAVE YOU EVER:**
- Been knocked unconscious?
- Used a crutch, or other support?
- Been treated for a spine or nerve disorder?
- Had a fractured bone?
- Been hospitalized for other than surgery?
- Ever had surgery? (list below)

Pregnant Yes No
 Date of last period _____
 Previous miscarriages Yes No

*Please list any prescription drugs now taken, allergies and past surgeries- _____

**CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAD:
 CIRCLE ITEMS THAT ARE COMMON TO OTHER FAMILY MEMBERS**

- | | | | | | |
|---|--------------------------------------|--|---|--|---|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Malaria | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Foot Problems | <input type="checkbox"/> Measles | <input type="checkbox"/> Polio | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Goiter | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Gout | <input type="checkbox"/> Mumps | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Stroke | |

After reading and filling out the case history, your signature will verify that all the information you have given us is accurate and that you have read the case history questions entirely.

Sign your name _____ Date _____

**FEES PAYABLE WHEN SERVICE RECEIVED UNLESS SPECIAL ARRANGEMENTS ARE MADE
 CASE HISTORY**

**LANCASTER DEPEW CHIROPRACTIC
345 DICK ROAD
DEPEW, NEW YORK 14043**

**DR. KEVIN E. CICHOCKI, D.C.
DR. JASON CICHOCKI, D.C.
DR. PETER GUZINSKI, D.C.**

PATIENT NOTIFICATION OF FINANCIAL RESPONSIBILITY

I understand that I may be financially responsible for any charges incurred at this office, including co-payments, deductibles, and charges denied or not covered by my insurance company.

I realize that my care may be subject to pre-authorization by my insurance company, and I accept all responsibility for any treatments, which are determined to be not medically necessary. I understand that my coverage does not cover routine maintenance, Preventative or well ness visits.

My initial office visit and examination is covered under my contract and will not be billed to me if continued treatment is determined to be medically necessary. Lancaster Depew Chiropractic will submit all required documentation to the insurance company, or their designee, so that a review relative to determination of medical necessity can be made fo subsequent treatment. I understand that both Lancaster Depew Chiropractic and my self will receive direct notification from the insurance company, or their designee, and will be advised as to whether additional treatment has been approved or denied and the number of visits that have been approved for a specified time period. Charges for services determined to be not medically necessary by the insurance company will be my responsibility.

Insurance policy limitation are per individual insurance policy plan, as are co-payments, co-insurance, deductibles, pre-authorization, and/or referrals.

I have read and understand my obligations for payment for care in the absence of insurance coverage.

PRINT PATIENT'S NAME

SIGNATURE (Patient, Parent or Guardian)

DATE

LANCASTER DEPEW CHIROPRACTIC

Dr. Kevin E. Cichocki, D. C

Dr. Jason D. Cichocki, D.C.

Dr. Peter Guzinski, D.C.

345 Dick Road, Depew, New York 14043

(716)681-3333

INFORMED CONSENT

Chiropractic, as well as 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 in contesting to treatment.

Specific Risk Possibilities Associated with Chiropractic Care are:

Stroke: Stroke is the most serious complication of Chiropractic treatment. It is rare. According to the journal of CCA, vol. 37, no.2, June 1993, recent studies estimate the risk of this type of stroke is 1 in every 3 million upper cervical adjustments. Vertebral arteries, which supply the brain with blood, are located within the bones of the upper spine. Therefore, cervical treatment poses a small risk for a stroke, which is temporary or permanent brain dysfunction. On extremely rare conditions, death occurs.

Soreness: Chiropractic adjustments are sometimes accompanied with post treatment soreness. This is normal, but please advise your doctor of Chiropractic of the soreness.

Soft Tissue Injury: Occasionally, Chiropractic treatment may aggravate a disc injury, or cause minor joint, ligament, tendon, or other soft tissue injury.

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

Physical Therapy Burns: Heat generated by physical therapy modalities can cause minor burns to the skin. These are rare, but should be reported, as well, as other side effects you may be experiencing.

Chiropractic is a system of health care delivery and therefore, as with any healthcare delivery system, we cannot promise a cure for any symptoms, condition or disease. An attempt to provide the best Chiropractic care is our goal, and if the results are not successful, we will refer you to another health care provider. If you have any questions, please ask your Doctor.

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

Patients Printed Name

Today's Date

Patients Signature

Parent/Guardian Signature if Minor