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 finacial 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	Burning	Aching	Stabbing
-----	OOOOO	^^^^^	XXXXX	●●●●●

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

1 2 3 4 5 6 7 8 9 10

DOCTOR'S NOTES

____

____

____

____

THIS IS A CONFIDENTIAL HEALTH REPORT

NAME____Date______________
(last) (first) (middle)

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
- ☐ ☐ Inadbility 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

Pregnant ☐Yes ☐No
Date of last period____________
Previous miscarriages ☐Yes ☐No

DATE OF LAST: (Approx.)
- _________Physical examination
- _________Blood test
- _________Chest x-ray
- _________Spinal x-ray
- _________Dental x-ray
- _________Urine test

	NONE	LIGHT	MODERATE	HEAVY
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
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)

*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

- ☐ Aids
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Foot Problems
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Malaria
- ☐ Measles
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Venereal Disease

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

Patient Responsibility Agreement

I,____, am a member of Univera Healthcare WNY
Your Name (please print)

(formerly HealthCarePlan/ChoiceCare), and I have scheduled treatment from

____(Provider) on________________________________*

I do not have a Univera Healthcare referral letter or authorization referral number. I understand that the referral letter or an authorization number is required prior to scheduling this visit in order to assure that it is a covered benefit. I have decided I want to continue with this visit today.

I understand and agree that if I do not obtain the requires Univera Healthcare WNY referral letter/or authorization within five (5) business days of the date of service and deliver it to the Provider's office, then I will be responsible for payment of charges and will be billed directly. Univera Healthcare-WNY,Inc., Shall not be resposible for any charges connected with this unauthorized visit.*

____ _______________________
Signature of Patient or Guardian *Date*

____ _______________________
Signature of Witness *Date*

* *This form is only for the date specified.*

• *If you have a Unvera Access or another Univera Point-of-Service program, this visit may be eligible for coverage under your out-of-network benefit. The care you receive must be medically necessart, and you will be resposible for coinsurance, deductables, and any additional costs in exess of allowable charges. See your Subscriber Agreement for details.*

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 I 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