

Dobbs Ferry Chiropractic
& Holistic Health Center

63 Main Street, Dobbs Ferry, NY
T: 914.693.4545 / F: 914.231.6672

PERSONAL HISTORY

Date: _____ Social Security No: _____

Name: _____ Address: _____

City: _____ State: _____

Hme #: _____ Cell #: _____ Bus #: _____ Email: _____

Birth date: _____ Age: _____ Sex: M F

Business/Employer: _____ Type of Work: _____

Check One: Married Single Widowed Divorced Separated No. of Children: _____

Name of Emergency Contact: _____ Phone No: _____

Referred to this office by: _____

Who is responsible for your bill: Self Spouse Workman's Comp. Medicaid Medicare

Auto Insurance Personal Health Insurance Other: _____

CURRENT HEALTH CONDITION

Purpose of this appointment: _____

Other doctors seen for this condition: _____

When did this condition begin? _____

If disabled from work, please give dates: _____

Job related Auto related

Drugs you know take: Nerve Pills Pain Killers/Muscle Relaxers Blood Pressure Medicine

Insulin Other: _____

PAST HEALTH HISTORY

Please Check or Describe:

Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia

Broken Bones Other: _____

Major Accidents or Falls: _____

Hospitalization (other than above): _____

Previous Chiropractic Care: None

Doctor's name & approx. date of last visit: _____

Have you been treated for any health condition in the last year? Yes No

If yes, please explain: _____

BELOW IS A LIST OF CONDITIONS WHICH MAY SEEM UNRELATED TO THE PURPOSE OF YOUR APPOINTMENT. HOWEVER, THESE QUESTIONS MUST BE ANSWERED CAREFULLY AS THESE PROBLEMS CAN EFFECT YOUR OVERALL DIAGNOSIS, TREATMENT PLAN AND POSSIBILITY OF BEING ACCEPTED FOR CARE.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Malaria | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Venereal Infection |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Typhoid Fever | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Measles | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Eczema |

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- | | |
|---|---|
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Gas/Bloating After Meals |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Black/Bloody Stool |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Joint Pain/Stiffness | |
| <input type="checkbox"/> Walking Problems | |
| <input type="checkbox"/> Difficult Chewing/Clicking jaw | |

FEMALES ONLY:

When was your last period? _____
 Are you pregnant? Yes No Maybe

NERVOUS SYSTEM CODE

- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities

GENERAL CODE

- Allergies
- Loss of sleep
- Fever
- Headaches

GASTRO-INTESTINAL CODE

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Trouble
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

GENITO-URINARY CODE

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

C-V-R CODE

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling

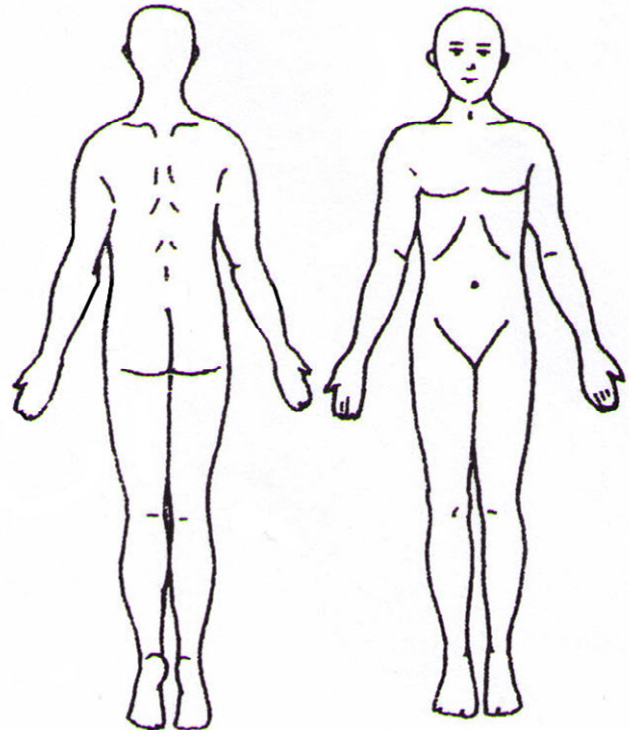
EENT CODE

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

MALE/FEMALE CODE

- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pain/Infections
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Genital Herpes

PLEASE OUTLINE ON THE DIAGRAM THE AREA OF YOUR DISCOMFORT



1 2 3 4 5 6 7 8 9 10

PLEASE INDICATE THE SEVERITY OF PAIN (10 BEING THE WORST)

DO NOT WRITE BELOW THIS LINE

Diagnosis:

Patient Accepted: Yes No

 Doctor's Signature

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic care (Comprehensive Care). Your doctor will weigh your needs and desires when recommending your treatment program.

If this is an accident related injury, please fill out the Accident Form. Thank You!

THE PURPOSE OF OUR CHIROPRACTIC CENTER IS TO SUPPORT EACH INDIVIDUAL IN ACHIEVING THEIR OPTIMUM HEALTH AND TO EDUCATE THEM SO THAT THEY MAY UNDERSTAND HEALTH AND CHIROPRACTIC AND IN TURN EDUCATE OTHERS.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, 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.

Patient's Signature _____ SS# _____ Date _____

Guardian or Spouse's
Signature Authorizing Care _____ Date _____