

# Confidential Patient Information

Barnes Chiropractic

At the Body Mind Center, 360 Parrish St., Canandaigua, NY 14424  
585-396-6679 / Fax 585-396-6695

Patient Information						
Last Name	First Name	MI	Gender M    F	Age	Birth Date	
Address			City		State	Zip
Home Phone #	Work Phone #	Cell #		Email		
In case of an emergency contact		Marital Status M   S   W   D		#of Children	Social Security #	
Referred By	Employer	Address			Phone	
Primary Care Physician Information						
Doctor's Last Name		First Name			Phone #	
Address			City		State	Zip
Have you seen your primary doctor for this complaint? <input type="checkbox"/> No <input type="checkbox"/> Yes, Date: _____		Date of Last Physical Exam:		Was exam normal, if not please explain:		
Insurance Information						
Insurance Carrier		Policy #			Group #	
Name of Subscriber			Birth Date		SSN	
Is your condition due to <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Other		If yes, when and where did the accident occur?				
Auto / Workers Comp Insurer			Phone #		Claim#	
Employer and Address						

I hereby direct \_\_\_\_\_ to pay by check made out and mailed directly to Alicia L Barnes, at the above address. My signature below is a direct assignment of my rights and benefits under this policy. I also authorize the release of any information pertinent to my case to any insurance company, adjustor, or attorney involved in this case.

Payment is expected at the time services are rendered. Keep in mind that the financial obligation for chiropractic treatment is between you and our office and is not dependent upon insurance coverage. We will provide you with receipts with pertinent information for you to be reimbursed by your insurance company. Barnes Chiropractic is not participating with Medicare, however, we will file the necessary forms and payment will be mailed to you.

As a patient of this office you agree to keep all your appointments. If for some reason you need to reschedule your appointment please contact our office within 24 hours or a \$40.00 charge will be applied to your account, which is not covered by insurance. Please reschedule all missed appointments within 7 days in compliance with your care-plan.

This office accepts cash, check, Visa, Mastercard, and Discover. Any checks returned for insufficient funds will be charged a \$30.00 fee. Any unpaid, unresolved balances will be forwarded to our collections agency after 30 days.

Patient's Signature: \_\_\_\_\_

Date \_\_\_\_\_

Drs. Initials \_\_\_\_\_

Date \_\_\_\_\_

**Family History**

Do you have a family history of Cancer, Heart disease, Diabetes, Auto-immune Conditions or Arthritis?  
(If yes, please list family member, whether living, age and condition of disease.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Previous Medical History**

Surgeries, Hospitalizations, Serious Illnesses (List Year in Brackets): \_\_\_\_\_

\_\_\_\_\_

Fractures, Dislocations, Major Dental Work (List Year in Brackets): \_\_\_\_\_

\_\_\_\_\_

Have you been in an auto accident: past year past 5 years over 5 years never

If yes, briefly describe \_\_\_\_\_

\_\_\_\_\_

Have you had any other personal or job related injury or accident? past year past 5 years over 5 years never

If yes, briefly describe \_\_\_\_\_

\_\_\_\_\_

**Current Health Information**

Have you had previous Chiropractic Care? If so, when was your last visit? \_\_\_\_\_

Name and Contact of Chiropractic Office? \_\_\_\_\_

What is your major complaint? \_\_\_\_\_

Was this complaint precipitated by a specific event/incident? \_\_\_\_\_

Have you had this or similar conditions in the past? \_\_\_\_\_

When did this condition first begin: \_\_\_\_\_ Is it getting progressively worse: Yes No Constant Comes and Goes

Is this condition interfering with your: Work Sleep Daily Routine Other \_\_\_\_\_

What activities aggravate your condition? \_\_\_\_\_

Have you seen any other doctors for this condition? \_\_\_\_\_

Are you currently being treated for any other medical conditions? If yes please list condition and treating doctor(s).

\_\_\_\_\_

Are you currently taking any medication or vitamin supplements? If yes, please list. \_\_\_\_\_

\_\_\_\_\_

Drs. Initials \_\_\_\_\_

Date \_\_\_\_\_

Patients Initials \_\_\_\_\_

Date \_\_\_\_\_

Please list all symptoms that you are experiencing today. Rate the severity and frequency of the symptom using the scale below each line.

1) Symptom - \_\_\_\_\_ Onset Date \_\_\_\_\_

No pain -0 1 2 3 4 5- Extreme Pain      Frequency: Occasional Intermittent Frequent Constant

What makes it feel better? \_\_\_\_\_ What makes it feel worse? \_\_\_\_\_

2) Symptom - \_\_\_\_\_ Onset Date \_\_\_\_\_

No pain -0 1 2 3 4 5- Extreme Pain      Frequency: Occasional Intermittent Frequent Constant

What makes it feel better? \_\_\_\_\_ What makes it feel worse? \_\_\_\_\_

3) Symptom - \_\_\_\_\_ Onset Date \_\_\_\_\_

No pain -0 1 2 3 4 5- Extreme Pain      Frequency: Occasional Intermittent Frequent Constant

What makes it feel better? \_\_\_\_\_ What makes it feel worse? \_\_\_\_\_

4) Symptom - \_\_\_\_\_ Onset Date \_\_\_\_\_

No pain -0 1 2 3 4 5- Extreme Pain      Frequency: Occasional Intermittent Frequent Constant

What makes it feel better? \_\_\_\_\_ What makes it feel worse? \_\_\_\_\_

### Pain Diagram

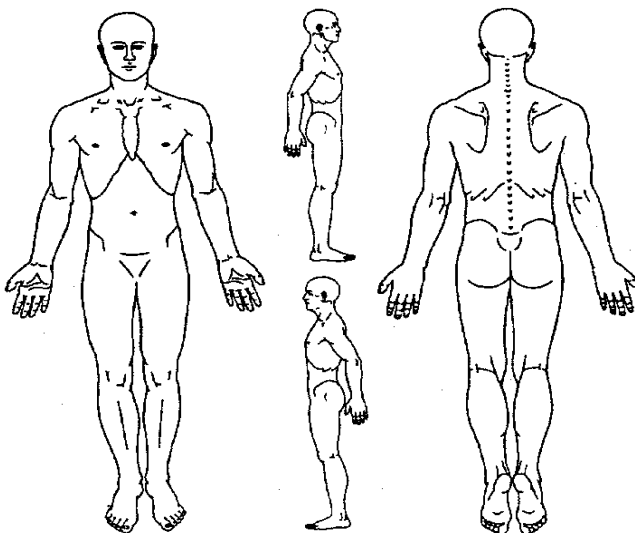
On the following diagram, please indicate all areas of

Pain - XXX

Stiffness - ///

Numbness - OOO

Other (specify) - \_\_\_\_\_



Drs. Initials \_\_\_\_\_

Date \_\_\_\_\_

Patients Initials \_\_\_\_\_

Date \_\_\_\_\_