Astoria Chiropractic
29-15 Astoria Blvd.
Astoria, NY 11102

Tel.: 718-626-6666
Fax: 718-626-8788

New Patient Form

Please fill out completely, print, sign and date the form and bring with you to your first appointment

Patient Name: Last _____ First _____ M ____SS# _____

Address _____City _____ State_____Zip_____

Email Address: _____ Home #_____ Cell # _____

Date of Birth: _____ Referred By: _____ Status ☐S ☐M ☐D ☐W Gender ☐ M ☐ F

Occupation _____ Employer _____Work # _____

Employer's Address_____City _____ State_____Zip_____

In Case of an Emergency

Who should we contact? _____Relationship: _____

Home Phone #: _____Work Phone #: _____ ext._____

Reason For Visit

The reason for this visit is a result of: ☐Work ☐Sports ☐Auto ☐Chronic ☐Trauma ☐Unknown

When did the condition begin: _____ Is this condition getting worse? ☐Yes ☐No ☐Unchanged

Describe what happened: _____

Describe your 1° pain & its location: _____

Grade your Primary Complaints (how you feel today):

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain Unbearable Pain

How often are your symptoms present?

☐**0-25%** ☐**26-50%** ☐**51-75%** ☐**76-100%**

Describe the 2° pain & its location: _____

Grade your Secondary Complaints (how you feel today):

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain Unbearable Pain

How often are your symptoms present?

☐**0-25%** ☐**26-50%** ☐**51-75%** ☐**76-100%**

Have you been treated by another provider for this condition? ☐Yes ☐No _____

Have you had any spinal X-Rays, MRI's or CT Scans for your area(s) of complaint? If so, please list areas taken:

_____

If possible, please bring any films or reports related to your condition with you on your initial visit.

Have you ever been treated by a Chiropractor before? ☐Yes ☐No If so, whom? _____

Who is your Primary Medical Doctor? _____Phone #: _____

Lifestyle Information:

Do you:

☐Yes ☐No Do you smoke? _____ packs/day

☐Yes ☐No Exercise? How often? _____

☐Yes ☐No Vitamins or Supplements? (List below)

☐Yes ☐No Take Medications? (List below)

☐Yes ☐No Do you drink alcohol? _____ Units/day

☐Yes ☐No Do you wear Heel Lifts?

☐Yes ☐No Do you wear Orthotics?

☐Yes ☐No Do you Sleep Well? How old is your mattress? ___ Yrs.

List all medications and/or supplements you take:_____

_____

For Women:

☐Yes ☐No Are you taking Birth Control? ☐Yes ☐No Are you Pregnant? Weeks/ LMP? _____

Patient Medical Health History

List any allergies to foods, medications, etc.: _____

List any condition(s) you have or ever had: _____

List any past accidents with dates:_____

List any previous surgeries/treatments with dates: _____

Symptoms Survey:

Do you currently have or have you ever had any of the following conditions or diseases?

- ☐**Yes** ☐**No** Neck Pain or Stiffness
- ☐**Yes** ☐**No** Mid-Back Pain or Stiffness
- ☐**Yes** ☐**No** Lower Back Pain or Stiffness
- ☐**Yes** ☐**No** Tension or Migraine Headaches
- ☐**Yes** ☐**No** Tingling or Numbness in Arms/ Hands
- ☐**Yes** ☐**No** Tingling or Numbness in Legs/ Feet
- ☐**Yes** ☐**No** Shoulder/ Elbow/ Wrist Pain (Circle)
- ☐**Yes** ☐**No** High/ Low Blood Pressure
- ☐**Yes** ☐**No** Difficulty Breathing
- ☐**Yes** ☐**No** Asthma
- ☐**Yes** ☐**No** Sinus Problems
- ☐**Yes** ☐**No** Spine Surgeries/ Artificial Joints
- ☐**Yes** ☐**No** Heart Disease / Stroke / TIA (Circle)
- ☐**Yes** ☐**No** Neurological Conditions
- ☐**Yes** ☐**No** Anemia
- ☐**Yes** ☐**No** Fainting/ Seizures/ Epilepsy
- ☐**Yes** ☐**No** Osteoporosis/ Osteopenia
- ☐**Yes** ☐**No** Cancer, If yes, Please specify
- ☐**Yes** ☐**No** Chemotherapy/ Radiation
- ☐**Yes** ☐**No** Alcohol/ Drug Abuse
- ☐**Yes** ☐**No** Ulcers/ Colitis
- ☐**Yes** ☐**No** Hepatitis
- ☐**Yes** ☐**No** Meningitis
- ☐**Yes** ☐**No** Diabetes/ Tuberculosis
- ☐**Yes** ☐**No** Psoriatic Arthritis

Family Medical Health History:

Do any members of your immediate family have or ever had any medical conditions listed above? If yes, please list:

_____

Insurance Information

Insurance Co. Name: _____ Tel. #: _____

Address: _____ City: _____State: _____ Zip: _____

Insured's Name: _____ Date Of Birth: _____/_____/_____

Insured's ID#: _____ Group #:_____ Relationship to Insured: _____

No-Fault/ Worker Comp. Ins. Co.:_____ Tel. #: _____

Address: _____ City: _____ State: _____ Zip: _____

Claim #: _____WCB Case #:_____ Date of Injury:____/_____/_____

_____

I hereby authorize assignment of my insurance rights and benefits to be paid directly to the provider of services rendered at Astoria Chiropractic. It is the policy of some insurance companies to pay the subscriber (patient) directly in certain cases. I fully understand that if I receive any payment directly from my insurance company for services rendered by any provider at Astoria Chiropractic. I am solely responsible to sign over such insurance checks. In the event that I deposit these checks into my account or negotiate them, I am responsible for reimbursing the provider that rendered these services for an equal amount.

Astoria Chiropractic requires all payments in full for services rendered at the time of the visit, unless other arrangements have been made with the business manager. If you want to discuss any financial matters, please inform the front desk prior to treatment.

We encourage you to inform the front desk if you want to discuss any questions you have regarding our services or billing practices. This promotes a greater confidence and trust between our patients and staff, thus resulting in a more comfortable experience and healing environment. I understand the information in this form and completed it truthfully to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in the provided information that may occur in the future.

As the parent or legal guardian of the minor listed above, I hereby authorize the providers at this office and their assistants to administer care as necessary.

_____ _____ _____

Signature Relationship Date