Sikorsky Chiropractic & Fitness

Confidential Patient Information

Today's Date____/____/____

Name _____ Nickname _____

Address

_____

City _____ State _____ Zip

_____

Phone (_____)_____

Work Phone _____

E-Mail Address _____

S.S.# _____

D.O.B. _____/_____/_____

Marital Status: M S D W

Spouse Name _____

How Many Children? _____

Nearest Relative _____

Phone # _____

Referred by:

_____

Occupation _____ Company Name _____

Company Address _____ City _____ State _____ Zip_____

How do you want to be contacted?

Reminder Phone Calls: Yes or No

Can we leave a voicemail? Yes or No

Can we leave a message if someone else answers? Yes or No

Would you want to receive our emails? Yes or No

Would you like to receive snail mail? Yes or No

Pain Relief today, Health for a lifetime!

About Your Condition

Date symptoms appeared or accident happened _____/_____/_____
What are your PRESENT symptoms and complaints? _____
Have you ever had the same or similar condition ( )Yes ( ) No. If yes, please describe: _____
_____
What activities aggravate your condition? _____
Is condition due to your employment: ( )Yes ( ) No
Have you lost time from work as a result? ( ) Yes ( )No
Have you been treated by another doctor for this condition? ( )Yes ( )No If yes, please list doctor's name and address:
_____
What type of treatment did you receive? _____
Date of last Physical Exam _____/_____/_____ Female: are you pregnant? ( )Yes ( )No
What operations or serious illnesses have you had? _____
What medications or drugs are you taking? _____
Have you ever been under Chiropractic care? ( )Yes ( )No Doctor's Name _____
Is this condition getting progressively worse: ( ) Yes ( )No ( ) Constant ( ) Comes and goes
Is this condition interfering with: ( )Work ( )Sleep ( )Daily Routine ( )Other
Do you notice any activity restrictions as a result? ( )Yes ( )No. Describe _____
Please include any other concerns you have regarding your visit today? _____
_____

CHECK THE SYPTOMS YOU HAVE NOTICED SINCE THE CONDITION STARTED

___Headache	___Irritability	___Numbness in Toes	___Face Flushed	___Feet Cold
___Neck Pain	___Chest Pain	___Shortness of Breath	___Buzzing in Ears	___Hands Cold
___Stiff Neck	___Dizziness	___Fatigue	___Loss of Balance	___Stomach Upset
___Sleeping Problems	___Heads Seems Heavy	___Depression	___Fainting	___Constipation
___Back Pain	___Pins & Needles in Arm	___Light Bothers Eyes	___Loss of Smell	___Cold Sweats
___Nervousness	___Pins & Needles in Legs	___Loss of Memory	___Loss of taste	___ Fever
___Tension	___Numbness in Fingers	____Ears Ring	___Diarrhea	_____

HAVE YOU *EVER* SUFFERED FROM THE FOLLOWING

			TINGLING OR NUMBNESS	
___Headache	___Stroke	___Colon Problems	___Shoulder	___Hips
___Cancer	___ Chest Pain	___Urinary Abnormalities	___Arms	___Legs
___Significant Weight Gain/Loss	___ Dizziness	___Kidney Infection or Stones	___Elbows	___Knees
___Spinal Curvature	___High Blood Pressure	___Prostate Trouble	___Hands	___Feet
___Tuberculosis	___Persistent Cough	___Menstrual Problems		
___Enlarged Thyroid	___Asthma	___Lumps in Breast		
___Heart Problems	___Stomach Problems			

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. I acknowledge full responsibility for payment of services to Sikorsky Chiropractic Clinic, S.C. and Dr. Sikorsky and agree to pay them in full AT THE TIME OF SRVICE, unless other arrangements are made in advance. Furthermore, I understand that this chiropractic office will prepare necessary reports and forms to assist me in making collections from the insurance companies and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. All fees are due and payable within 60 days of being released from care. 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, in either case I will pay a monthly rebilling fee of 2% of the outstanding balance for any late payments. I further understand and agree I will pay court costs, filing fees, court appearance fees, in addition to collection agency and/ or attorney's fees of 1/3 of the outstanding balance, if my account is ever referred to same.

Patient Signature _____Date_____
Guardian's or Spouse's signature authorizing care_____
Comments _____