



Cooperstown Family Chiropractic

4910 State Highway 28
Cooperstown, NY 13326
(607)282-4140
Fax: (607)282-4144



cooperstownfamilychiropractic@gmail.com

Name: _____ Date: _____

First M.I. Last

Address: _____ City: _____ State & Zip: _____

Date of Birth: ____/____/____ Male / Female Social Security #: ____-____-____

Circle: Married Single Widowed Divorced: Partner Partner/Spouse's Name: _____

Home #: () _____ Work #: () _____

May we contact you at work? YES NO Cell / Pager #: () _____

Email address: _____ @ _____ . _____ (for official office use only)

Occupation: _____ Employer's Name: _____

Address: _____ City / State / Zip: _____

Medical Doctor: _____

Name Address Phone Number

Date of Last Visit Reason

May we have your permission to send them a report to keep them up to date? Yes No

Have you had spinal x-rays taken? Yes No When _____

Health subjects that interest you :

Wellness Topics **Exercise & Fitness** **Children's Health Issues** **Stress Management**
Women's Health Diet & Nutrition **Headaches & Neck Pain** **Backaches & Sciatica**

Emergency Contact (Partner in Health):

_____/_____()_____
Name Relationship Phone

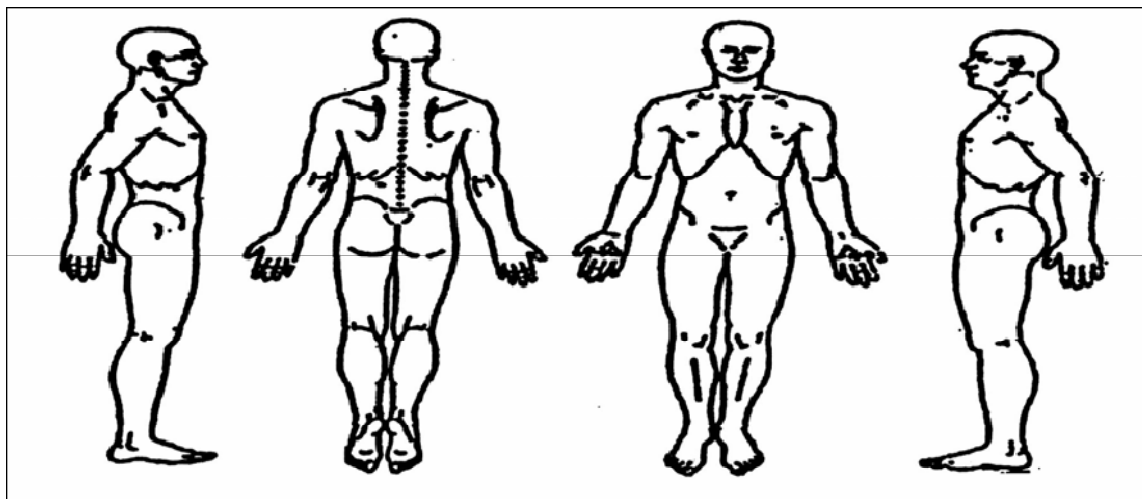
Who referred you to us/how did you hear about our office? _____

May we thank them? Yes No

1. Is today's problem caused by: Auto Accident Workman's Compensation N/A

2. Indicate on the drawings below if you have pain/symptoms (draw below)

If you are here for wellness and there are no current or recurring symptoms, then skip ahead to question # 15



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3. How often do you experience your symptoms?

- Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- Sharp Numb Dull Tingly Diffuse Sharp with motion
 Achy Shooting with motion Burning Stabbing with motion
 Shooting Electric like with motion Stiff Other: _____

5. How are your symptoms *changing* with time?

- Getting Worse Not Changing Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem/problems? (Please circle) No Pain 0 1 2 3 4 5 6 7 8 9 10 Hospitalization

7. How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

8. How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

9. Who else have you seen for your problem?

Name

- Chiropractor Neurologist Primary Care Physician
 ER physician Orthopedist Other: _____
 Massage Therapist Physical Therapist No one

10. How long have you had this problem? _____

11. How do you think your problem began? _____

12. Do you consider this problem to be severe? Yes Yes, at times No

13. What aggravates your problem?

- Sitting Standing Exercise Bending Lifting Walking
 Sleep/sleeping positions Other _____

14. What makes your problem feel better?

- Ice Heat Massage Yoga Stretching Exercise Chiropractic Care
 Over the counter medication Prescription Medication Other _____

15. What concerns you the most about your problem (Please Pick Only One)?

- Could be Serious Not Going Away Getting Worse Affecting Work Affecting Sleep
 Affecting Mental Outlook Affecting Relationships Affecting Leisure Other: _____

16. What is your: Height _____ Weight _____ lbs

17. How would you rate your overall Health? Excellent Very Good Good Fair Poor

18. Indicate if you have any immediate family members with any of the following:

- Rheumatoid Arthritis Diabetes Lupus Heart Problems Cancer ALS
 Hyper/Hypothyroid

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19. What impact do you believe your family history has on your own health?

- None Mild Moderate Extreme

20. For each of the body signals listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Abuse
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Ear Infections
<input type="checkbox"/>	<input type="checkbox"/> Allergies/Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/> Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/> Intestinal Problems
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/> Cold Sores
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite	For Females Only	
<input type="checkbox"/>	<input type="checkbox"/> Jaw pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Menstrual Problems
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder	<input type="checkbox"/>	<input type="checkbox"/> Menopausal Symptoms
<input type="checkbox"/>	<input type="checkbox"/> Cancer/Tumor	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue	<input type="checkbox"/>	<input type="checkbox"/> Hormone Replacement
<input type="checkbox"/>	<input type="checkbox"/> Stress	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination		
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances		
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness/Fainting		
<input type="checkbox"/>	<input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/> Sleeping Problems		

28. Have you seen a chiropractor before? No Yes

If yes, who: _____ how long ago: _____ results were: Good Mixed Bad

22. List any prescription medications or over-the-counter medications you are currently taking:

23. List any nutritional supplements you are currently taking:

29. Have you had significant past trauma? No Yes, if yes list: _____

27. Have you ever been hospitalized? No Yes, if yes, why _____

24. List all surgical procedures you have had and date:

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25. What activities do you do at work?

- Sit: Most of the day Half the day A little of the day
- day
- Stand: Most of the day Half the day A little of the day
- Computer work: Most of the day Half the day A little of the day
- On the phone: Most of the day Half of the day A little of the day
- Drives: Most of the day Half of the day A little of the day
- Other: Manual Labor Reads a lot Travels a lot

30. Anything else pertinent to your visit today? _____

LIFESTYLE / STRESS SURVEY

Pre-birth: (start here because mother was you neurological connection before your birth)

- Were you a first born child? **Yes No**
- Did she smoke with you? **Yes No**
- Did she drink with you? **Yes No**
- What was her diet like? **Poor Good Average Excellent**
- Was she on any medications? **Yes No**
- Did your mother have any significant emotional stress while carrying you? **Yes No**
- Was she involved in any auto accidents? **Yes No**
- How many ultrasounds were performed on you?

Birth:

- Were you early or late? **Early On Time Late**
- Was it a short or long delivery? **Short Long Unsure**
- Born in the hospital, home, Birthing Center? **Hospital Home Birthing Center**
- Circle: **C- Section Vaginal Labor Induced Rx Epidural Forceps Vacuum**
- Where there any complications afterward? **Yes No**

Childhood:

- Were you nursed? Yes, How long? _____ No
- Drink Cows milk? Yes, When _____ No
- What was your diet like? Poor Good Average Excellent.
- Were you in athletics? Yes, What? _____ No
- Anyone in home smoke? Yes, How much? _____ No
- Were your parents Healthy in the earlier years of your life? Yes No
- Any significant or memorable falls? _____
- Any significant or memorable stress between parents or siblings? _____
- Were you vaccinated? Yes, Any Reactions? _____ No
- Were there any deaths or divorces or serious emotional stressors during this period? **Yes No**

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Adolescence:

- Did you take any antibiotics? Yes, About how many # _____ No
- What was your diet like? **Poor Good Average Excellent**
- Were you in athletics? Yes, What? _____ No
- Anyone in home smoke? Yes, How much? _____ No
- Did you use tobacco? Yes, How much? _____ From _____ No
- Did you use any other drugs? Yes No _____
- Any significant or memorable falls or accidents? _____
- Any significant or memorable stress with family members? _____
- Were there any deaths or divorces or serious emotional stressors during this period? **Yes No**
-
-

Adulthood:

- Take any antibiotics? **Yes**, About how many # _____
- What was your diet like? **Poor Good Average Above Avg. Excellent.**
- Were you in athletics? **Yes**, What? _____ **No**
- Anyone in home smoke? **Yes**, How much? _____ **No**
- Did you use tobacco? **Yes**, How much? _____ From _____ **No**
- Did you use any other drugs? **Yes No** _____
- Any significant or memorable falls or accidents? _____
- Any significant or memorable stress with family? _____
- Where there any deaths or divorces or serious emotional stressors during this period? **Yes No**
-
-

Currently:

- How many hours of sleep do you get on an average night? _____
- Do you have problems getting to sleep or staying asleep? Yes No
- How many servings of fruits and vegetables do you consume in a day? _____
- How many times a week do you eat fast food? _____
- How many ounces of water do you drink in a day? _____
- What type of exercise do you do? Strenuous Moderate Light None
- What type? _____ How often? _____

Habits:	None	Light	Moderate	Heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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HIPPA INFORMATION

DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

1. I give permission to Cooperstown Family Chiropractic to use my address, phone number and clinical records to contact me with birthday cards, newsletters, patient letters, thank-you cards, first adjustment calls, testimonials and information about treatment alternatives or other health related information.
2. By signing this form you are giving Cooperstown Family Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Cooperstown Family Chiropractic. The written notice must contain the following information:

Your Name, Social Security Number and Date of Birth; A Clear Statement of Your Intent to Revoke This AUTHORIZATION; The Date of Your Request and Your Signature.

I have read and agree to the financial policy and HIPPA privacy policy set above. Furthermore should I for any reason, discontinue care, I understand that the entire balance for professional services rendered to date will be due within 30 days. I agree that you may release my information to my insurance agent / adjuster or their agents regarding my care in this office. I also understand that the records including x-rays are a permanent record and are the property of Cooperstown Family Chiropractic. These records will be released at my request in writing. A copy of this agreement will serve as the original. You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Cooperstown Family Chiropractic will not refuse to provide treatment.

Name (printed) _____

Signature of Patient / Guardian _____

Notice: It is important that our patients and we have the same health objectives regarding chiropractic care. Regardless of **what a disease or condition is called, we do not offer to treat it.** Our only practice objective is to eliminate a major interference to the expression of the body's innate and internal wisdom. Our only method is specific adjusting to correct vertebral subluxations. We believe that the greatest Doctor is the one already inside of each of our patients, and we only help to maximize their inherent healing power without the use of drugs or surgery.

Disclosures: I authorize this office to release any information requested by my insurance company or other health care individuals to document my claim for benefits or assist in further health care purposes. The above information was completed correctly to the best of my knowledge and I understand that it is my responsibility to inform this office of any changes in my health status or financial status.

Signature _____

Signature of Patient / Guardian _____

Date _____

Consent to evaluate and adjust a minor child: I, _____, being the parent or legal guardian of have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature _____ Date _____

Pregnancy Release: This is to certify that to the best of my knowledge I am not pregnant and Drs. Jill and Matthew Craig have my permission to perform an x-ray evaluation. I have been advised that an x-ray can be hazardous to an unborn child. Date of last menstrual period: _____

Signature _____ Date _____

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Payment Policy

There are two forms of payment:

Cash- every time you come in.

OR

Insurance Assignment- Co-Pay, insurance reimbursement signed over to our clinic.

Insurance Assignment Program

It is our desire to assist our practice members whenever possible. The following insurance assignment program allows you, our patient, to receive the care you need without undue financial strain.

1. Waiting for insurance payment is a courtesy provided by this clinic. We reserve the right to withdraw this courtesy at any time. We will bill your insurance company and accept assignment of benefits during your corrective care period. Direct assignment will be discontinued when you have finished your corrective care and a wellness health care program is recommended we will notify you of the change.
2. It is your responsibility to pay all deductible amounts. Also, you must stay current with your percentage of responsibility or copayment. This must be at least paid weekly. Prepayments may also be made.
3. The insurance carriers are billed on specific 7 day cycles. It is your responsibility to provide this office with the necessary forms to complete billing if needed.
4. If you receive payment from your insurance carrier during the period that this clinic has accepted assignment of benefits, you are to bring the check to this office within 3 business days and endorse it over to this office. Failure to do so will result in collection action.
5. If you discontinue care for any reason, you will be responsible for any unpaid balance. There will be a \$35.00 fee for all returned checks.
6. This clinic does not promise that an insurance company will pay. In the event that the insurance company denies or rejects the claim, it is the responsibility of the patient to pay all charges and pursue reimbursement from the insurance company on his/her own.

I have read the above provisions and wish to participate in the insurance assignment program. I hereby agree to abide by the provisions outlined above.

Signature: _____ Date: _____

Name: _____

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