Glen Cove Chiropractic & Physical Therapy
Glen Cove Physical Medicine
189A Forest Ave., Glen Cove, NY 11542
516-759-2032

Name _____ Email _____

Home Address _____ Home Phone _____

City _____ Work Phone _____

State, Zip _____ Cell Phone _____

SS #: _____ Date of Birth _____ Sex M F

Medical Doctor _____ Referred By _____

Employers Name _____ Occupation _____
(If Minor, Parent's Employer)

Employer's Address _____

Spouse's Name _____ Spouse's Employer _____

Your Insurance Information

❑ Major Medical Insurance ❑ Medicare ❑ Worker's Comp ❑ Auto Accident ❑ Other: _____

How will you pay today? ❑ Cash ❑ Check ❑ Credit Card (MC / Visa)

Name of Insurance Co _____ Are You Policy Holder? ❑ Yes ❑ No

* If not you, Who? _____ Policy Holder's SS # _____

Policy Holders Date of Birth _____ Policy Holder's Employer _____

1. Major Complaint _____

2. Please describe your pain ❑ Stab ❑ Sharp ❑ Aches ❑ Dull ❑ Weakness ❑ Numb ❑ Shooting

3. Your complaint: ❑Constant(76-100%) ❑Frequent(51-75%) ❑Occasional(26-50%) ❑Intermittent(25%/less)

4. How painful is your pain/condition? Circle one: No Pain..1 2 3 4 5 6 7 8 9 10 … Unbearable pain

5. When did your problem begin? Specific date if possible _____

6. Since your pain began, is the pain: ❑ Increasing ❑ Decreasing ❑ Not Changing

7. How did your problem begin: (Please check all that apply)

❑ Immediately after incident ❑ Multiple incidents ❑ Gradually over time ❑ No specific reason

8. What treatment have you already received? ❑ Surgery ❑ Physical Therapy ❑ Drugs ❑ Other: _____

9. What makes you feel better? ❑ Lying Down ❑ Walking ❑ Standing ❑ Sitting ❑ Movement ❑ Inactivity

10. What makes you feel worse? ❑ Lying Down ❑ Walking ❑ Standing ❑ Sitting ❑ Movement ❑ Inactivity

11. How would you grade your stress? ❑ No Stress ❑ Minimal Stress ❑ Moderate Stress ❑ Greatly Stressed

Please complete page #2

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If you are presently troubled by a particular symptom, check that symptom in the Present Column If you have ever had a listed symptom in the past, please check that symptom in the Past Column.

Please check any of the following that apply to you:

Never	Past	Present		Never	Past	Present	
❑	❑	❑	Neck Pain	❑	❑	❑	Fatigue
❑	❑	❑	Shoulder Pain	❑	❑	❑	Loss of Bladder Control
❑	❑	❑	Upper Arm or Elbow Pain	❑	❑	❑	Painful Urination
❑	❑	❑	Hand or Wrist Pain	❑	❑	❑	Frequent Urination
❑	❑	❑	Upper Back Pain	❑	❑	❑	Abdominal Pain
❑	❑	❑	Mid Back Pain	❑	❑	❑	Irregular Bowels
❑	❑	❑	Low Back Pain	❑	❑	❑	Difficulty Swallowing
❑	❑	❑	Hip or Upper Leg Pain	❑	❑	❑	Heartburn / Indigestion
❑	❑	❑	Lower Leg or Knee Pain	❑	❑	❑	Birth Control Pills Used
❑	❑	❑	Ankle or Foot Pain	❑	❑	❑	Pregnancy
❑	❑	❑	Jaw or TMJ Pain	❑	❑	❑	Dizziness / Blurred Vision
❑	❑	❑	Swelling / Stiffness of Joint	❑	❑	❑	Muscular In coordination
❑	❑	❑	Headaches	❑	❑	❑	Sinus Pain

Listed below are common diseases and disorders. Please indicate whether you have had a particular disorder in the past or are presently troubled by a listed disorder.

Never	Past	Present		Never	Past	Present	
❑	❑	❑	Depression	❑	❑	❑	Diabetes
❑	❑	❑	High Blood Pressure*	❑	❑	❑	Ulcer
❑	❑	❑	High Cholesterol*	❑	❑	❑	Heart Attack
❑	❑	❑	Gall Bladder Stones*	❑	❑	❑	Stroke
❑	❑	❑	Bladder Infection*	❑	❑	❑	Kidney Stones
❑	❑	❑	Asthma*	❑	❑	❑	Cancer
❑	❑	❑	Colitis*	❑	❑	❑	Prostrate Problems
❑	❑	❑	Irritable Bowel Syndrome*	❑	❑	❑	Anorexia
❑	❑	❑	Arthritis	❑	❑	❑	Blood Disorder
❑	❑	❑	Chronic Fatigue Syndrome	❑	❑	❑	HIV / AIDS
❑	❑	❑	Other: _____				

Are you interested in receiving information about a natural approach to:

Anti Aging ❑ Yes ❑ No ❑ I Don't Know

Detoxification Programs for Colon, Liver, Gall Bladder ❑ Yes ❑ No ❑ I Don't Know

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I attest that the above is true and correct to the best of my knowledge and authorize treatment. _____ _____ Date

I hereby authorize the attending Doctor to release any information concerning my examination and/or treatment _____ _____ Date

I hereby assign payment directly to this office for professional services rendered and I shall be responsible for any unpaid balance to the Doctor _____ _____ Date

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Electronic Health Records Information

In compliance with requirements for the government EHR incentive program

Preferred method of communication for patient reminders: ❑ Email ❑ Phone ❑ Mail

Email address (Clearly please): _____

Preferred Language: _____

Height: _____ Weight: _____ Blood Pressure (last time taken): _____

Smoking Status: ❑ Every day smoker ❑ Occasional smoker ❑ Former smoker ❑ Never smoked

CMS requires providers to report both race and ethnicity:
Race: ❑ American Indian/Alaska Native ❑ Asian ❑ Black/African American ❑ White/Caucasian
❑ Native Hawaiian/Pacific Islander ❑ Other ❑ Decline to answer

Ethnicity: ❑ Hispanic/Latino ❑ Asiatic ❑ European ❑ Decline to answer

Are you taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage & Frequency, Pill or Patch (ie 5mg once a day by pill, etc)

Do you have any medication allergies:

Medication Name	Reaction	Onset Date	Additional Comments

❑ I chose to decline receipt of my clinical summary after every visit (*these summaries are often blank as a result of the nature and frequency of chiropractic & physical therapy care).*

Patient Signature: _____ Date: _____