Welcome to

JWC HIROPRACTIC

115 West 45th Street, Suite 301 | New York, NY 10036
Phone: 212.922.9200 | Fax: 212.922.9553

Patient information (please print):

FIRST NAME _____ LAST NAME _____ DATE _____

ADDRESS _____ APT _____ CITY _____ STATE _____ ZIP _____

HOME PHONE ( ) _____ CELL ( ) _____ EMAIL _____

CONTACT PREFERENCE *(We normally remind patients by email day of their appointments, unless otherwise requested):* ☐ Call ☐ Email

MARITAL STATUS: ☐ Married ☐ Single ☐ Divorced ☐ Widowed GENDER ☐ Male ☐ Female

AGE _____ DATE OF BIRTH _____ # OF CHILDREN _____ SOC SEC # _____

OCCUPATION _____ EMPLOYER _____

ADDRESS _____ CITY _____ STATE ___ ZIP _____ PHONE ( ) _____

HOW DID YOU HEAR ABOUT THIS OFFICE? _____

Patient Condition:

HAVE YOU HAD CHIROPRACTIC CARE BEFORE? ☐ NO ☐ YES WHEN? _____ Dr. _____

WHEN DID YOUR PROBLEM BEGIN? _____ HOW DID IT HAPPEN? _____

DESCRIBE YOUR SYMPTOMS: _____

IS THE CONDITION GETTING PROGRESSIVELY WORSE? ☐ NO ☐ YES ☐ I DON'T KNOW

WHAT TYPE OF PAIN ARE YOU EXPERIENCING?

☐ **Sharp** ☐ **Dull** ☐ **Throbbing**
☐ **Aching** ☐ **Stiffness** ☐ **Tingling**
☐ **Numbness** ☐ **Shooting** ☐ **Other:** _____

HOW OFTEN DO YOU EXPERIENCE YOUR SYMPTOMS?

☐ **Constantly** (76-100%) ☐ **Frequently** (51-75%)
☐ **Occasionally** (26-50%) ☐ **Intermittently** (0-25%)

RATE YOUR PAIN ON A SCALE FROM 0-10? (Please circle)

0 1 2 3 4 5 6 7 8 9 10

(no pain) *(moderate pain)* *(severe pain)*

WHAT ACTIVITIES MAKE YOUR SYMPTOMS ***WORSE***?

☐ **Sitting** ☐ **Standing** ☐ **Walking** ☐ **Bending** ☐ **Lifting**
☐ **Lying Down** ☐ **Other** _____

WHAT ACTIVITES MAKE YOUR SYMPTOMS ***BETTER***?

☐ **Sitting** ☐ **Standing** ☐ **Walking** ☐ **Bending** ☐ **Lifting**
☐ **Lying Down** ☐ **Other** _____

HAVE YOU HAD SIMILAR SYMPTONS IN THE PAST?

☐ NO ☐ YES (Please explain) _____

_____

WHAT KIND OF WORK ACTIVITIES DO YOU PERFORM?

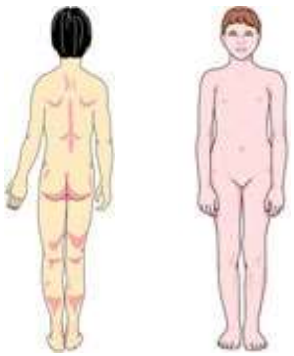
☐ **Sitting** ☐ **Standing** ☐ **Light Labor**
☐ **Heavy Labor**

HOW OFTEN DO YOU EXERCISE?

☐ **None** ☐ **Light** ☐ **Moderate**
☐ **Daily** ☐ **Heavy**

WHAT HAVE YOU DONE TO RELIEVE THE SYMPTOMS?

☐ **Prescription Medication** ☐ **Physical Therapy** ☐ **Surgery**
☐ **Homeopathic Remedies** ☐ **Acupuncture** ☐ **Massage**
☐ **Ice** ☐ **Heat** ☐ **Over the Counter Drugs** _____
☐ **Other** _____



Mark an "X" where you feel pain

Health History:

HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING? (Please check all that apply)

☐ **AIDS/HIV**	☐ **Anemia**	☐ **Arthritis**	☐ **Asthma**	☐ **Bleeding Disorders**	☐ **Breast Lumps**
☐ **Cancer**	☐ **Diabetes**	☐ **Epilepsy**	☐ **Gout**	☐ **Heart Disease**	☐ **Kidney Disease**
☐ **Dizziness**	☐ **Stroke**	☐ **Headaches**	☐ **Tumors**	☐ **Osteoporosis**	☐ **Pacemaker**
☐ **Prostate problems**	☐ **High Blood Pressure**	☐ **Digestive disorders**	☐ **Other** _____		

PLEASE LIST ANY PREVIOUS INJURIES OR SURGERIES: _____

ARE YOU PREGNANT? (**For women only**) ☐ NO ☐ YES If yes, how long? _____

PLEASE LIST ALL MEDICATION YOU ARE CURRENTLY TAKING AND THE DOSAGE: _____

_____

PLEASE LIST ANY ALLERGIES YOU HAVE AND YOUR REACTION: _____

_____

Emergency Contact

NAME: _____ CELL: _____ RELATIONSHIP: _____

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Insurance Information:

ARE YOU THE PRIMARY INSURANCE POLICY HOLDER? ☐ NO ☐ YES (If no, please complete the following policy holder's information)

NAME _____ DATE OF BIRTH _____ Relationship to Patient _____

ADDRESS _____ APT _____ CITY _____ STATE _____ ZIP _____

DO YOU HAVE SECONDARY INSURANCE? ☐ NO ☐ YES (If yes, please let the front desk know)

ASSIGNMENT OF BENEFITS AND POWER OF ATTORNEY TO CASH CHECKS

I, the undersigned, do hereby authorize payment directly to the office above, the benefits of my coverage, if any, otherwise payable to me for services but not to exceed the customary charge for those services. I understand that I am financially responsible for all charges whether or not paid by insurance. If these payments are made out to me I grant unto the office below as attorney the full power and authority in my name and stead to endorse any and all checks and drafts or money orders. I hereby authorize the doctor to release all information necessary to secure payment of benefits. A photocopy of this assignment shall be valid.

ERISA Authorization

I hereby designate, authorize, and convey to JW Chiropractic, the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from JW Chiropractic and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

Date: _____ Patient's Signature _____

ACKNOWLEDGEMENT STATEMENT

I, the undersigned, hereby declare that to the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Date: _____ Patient's Signature _____