Family Chiropractic . Dr. John Przybylak . Dr. Jessica D'Amore-Przybylak . 4017 Harlem Rd.Snyder, NY 14226 . 716.839.5100

Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

How did you hear about us? _____

Emergency Contact: _____

_____

Name: _____ **Date:** _____

Insurance: _____ (dd/mm/yr)

Date of Birth: _____ ☐ male ☐ female

Address: _____

_____

_____

Marital status

S	M	W	D	SEP

Phone #: home: _____ **work:** _____

E-mail address: _____

Occupation: _____ **Employer:** _____

Mark (c) for current problems, check ☑ and indicate the age when you had any of the following:

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

Muscle / Joint
- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

Eye, Ear, Nose & Throat
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsilitis
- ☐ Vision problems

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful defication
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Pus in urine
- ☐ Stress incontinence

Urination
- ☐ Overnight more than twice
- ☐ More than 8x in 24hrs
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

Women only
- ☐ Congested breasts
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Vaginal discharge

Menstrual flow
☐ Reg. ☐ Irreg. ☐ Pain / cramps
Days of flow: ____ Lenght of cycle: _____
Date - 1st day last period: _____
Are you pregnant? ☐ yes, ☐ no
If yes, how many months? _____
How many children do you have? _____
Birth control method: _____
Date of last PAP test: _____
☐ normal, ☐ abnormal
Date of last mamogram: _____
☐ normal, ☐ abnormal

Check any of the conditions you have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Please list any medication you are currently taking and why:

_____

_____

_____

_____

Patient Intake Form (side 2)

Give a breif detailed description of the problem you are currently experiencing: _____

_____

_____

_____

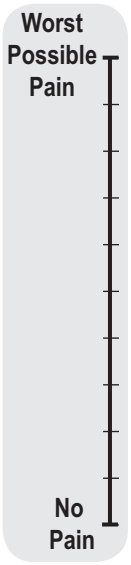
How long have you had this condition? _____ Is it getting worse? □ yes, □ no _____

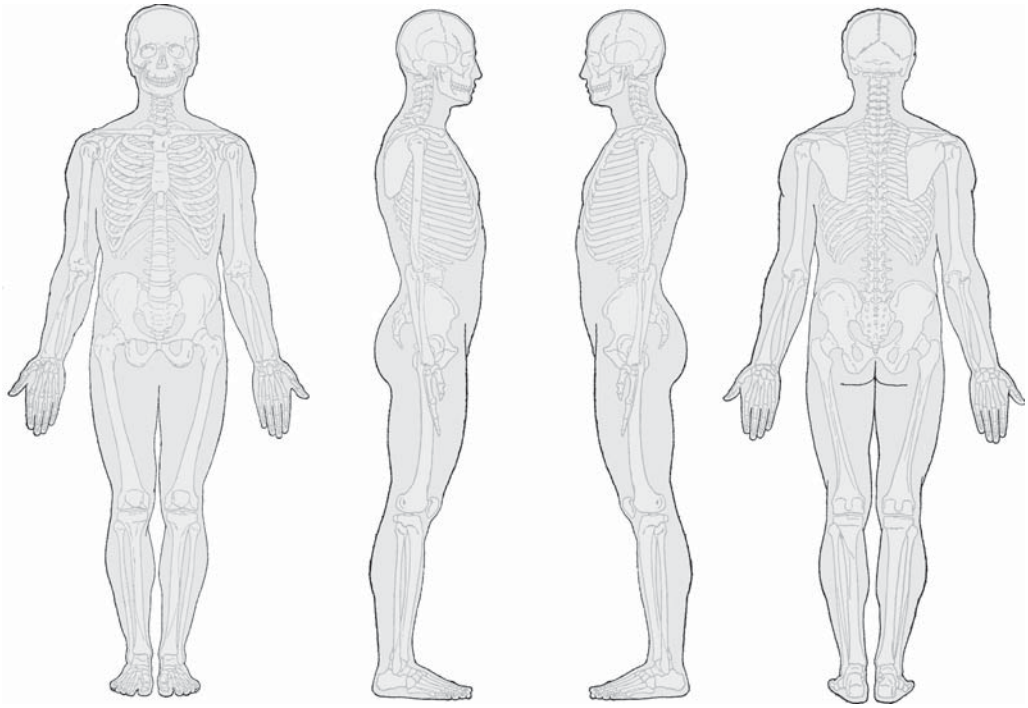
Does it bother you (check appropriate box): □ work, □ sleep, □ other: _____

What seemed to be the initial cause: _____

Please mark you area(s) of pain on the figure below

Please place a mark at the level of your pain on the scale below:





Past health history

Have you...	Yes	No	If yes, explain breifly
... been hospitalized in the last 5 year?	□	□	_____
... had any mental disorders?	□	□	_____
... had any broken bones?	□	□	_____
... had any strains or sprains?	□	□	_____
... ever used orthotics?	□	□	_____
Do you take minerals, herbs or vitamins?	□	□	_____

How is most of your day spent? □ standing, □ sitting, □ other: _____

How old is your matress? _____

When was your last physical exam? _____

Habits	none	light	mod.	heavy
Alcohol	□	□	□	□
Coffee	□	□	□	□
Tobacco	□	□	□	□
Drugs	□	□	□	□
Exercise	□	□	□	□
Sleep	□	□	□	□
Soft drinks	□	□	□	□
Salty foods	□	□	□	□
Water	□	□	□	□
Sugar	□	□	□	□

Family history

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

□ Alcoholism	□ Cancer	□ High blood pressure
□ Anemia	□ Diabetes	□ High cholesterol
□ Arteriosclerosis	□ Emphysema	□ Multiple sclerosis
□ Arthritis	□ Epilepsy	□ Osteoporosis
□ Asthma	□ Glaucoma	□ Stroke
□ Bleed easily	□ Heart disease	□ Thyroid disease

Do you have any other health issues or concerns that our staff should be made aware of? _____

_____

FAMILY CHIROPRACTIC

Family Chiropractic Fee Schedule

Examination $50 May be submitted to an Insurance Company for reimbursement.
Adjustment $42 May be submitted to an Insurance Company for reimbursement.
Child/Student Discount Adjustment $25 May NOT be submitted to an Ins. Co.
1st Additional Family Member Adjustment $25 May NOT be submitted to an Ins. Co.
2nd or More Additional Family Members $10 May NOT be submitted to an Ins. Co.

PRE- PAYMENT PLAN 10 visits $350
Normal cost $420 = savings of $70 / Over 16% savings
Must be paid in full & may not be submitted to insurance company for reimbursement.

A MONTH of Care $255
This is a CASH UP FRONT Discount for Intensive Care (12 visits. 12 x $42 = $504; **SAVINGS of $249!!).** This plan is designed for practice members who are serious about their commitment to being well. You must attend a 'Wellness Class' in order to qualify for this program. This MUST be PAID IN FULL, at the BEGINNING of each month, and MAY NOT be submitted to an Insurance Company. If you wish to submit your bills to an insurance company for reimbursement, you must pay the FULL adjustment amount $42 at the time of each service, then we would be happy to bill your company for you, as a courtesy.

A YEAR of Care $2550
This is a CASH UP FRONT Discount for Intensive Care (144 visits. 144 x $42 = $6048; **SAVINGS of $3,498!!** At 144 visits a year, 3X per week, that averages to **$17.70 a visit!!**). This plan is designed for practice members who are serious about their commitment to being well. You must attend a 'Wellness Class' in order to qualify for this program. This MUST be PAID IN FULL, at the BEGINNING of your year, and MAY NOT be submitted to an Insurance Company. If you wish to submit your bills to an insurance company for reimbursement, you must pay the FULL adjustment amount $42 at the time of each service, then we would be happy to bill your company for you, as a courtesy.

Our mission is to motivate you, encourage you, and move you & your family members toward greater levels of well-being.
Our Goal is to provide you with excellent care, outstanding service and fees that will allow you to receive the FULL benefit of chiropractic care. Chiropractic is an important part of the equation for good health.
Please feel free to discuss any questions or concerns regarding you finances with our office assistants. They are prepared and authorized to work with you to find the payment plan designed for your needs.
The Family Chiropractic Fee Schedule has bee thoroughly explained to me, I understand that I may ask to review these options at any time. If I have chosen a CASH UP FRONT or other DISCOUNTED option, and I wish to discontinue care before I reach the allotted number of visits, I will be refunded the balance in full minus $42 for each of the visits I used.

Signature _____ Date _____

Witness _____ Date _____

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FAMILY CHIROPRACTIC

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of focus to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(signature) (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.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: _____

_____ _____
(Signature) (date)

FAMILY CHIROPRACTIC

Acceptance of Responsibility

I, the undersigned, accept responsibility for any bills that I incur. If for any reason my insurance does not cover these expenses, I understand that I will be solely responsible. If my Insurance coverage includes a co-payment, I will also be responsible for the amount of each co-payment.

_____ _____

Signature Date