W e l c o me

Date: ____/____/____

Name: Date of Birth: / / Age:
Address: City: State Zip:

E-Mail: Home#: Work/Cell#:
Marital Status: # of children: Ages(s):
Occupation: How did you hear about me?

Present Complaint

Present complaint:_____
Pain or problem started on____/____/_____ How?_____
Pain is

- o dull
- o sharp
- o throbbing
- o burning
- o other _____
- o deep aching
- o tingling
- o stabbing
- o cramping
- o numbness
- o radiating
- o stiffness

Intensity/severity: (none) 0 1 2 3 4 5 6 7 8 9 10 **(**worst possible)
Does this complaint radiate or travel to any other area of your body? If yes, where?

_____
What activities **aggravate** your condition/pain?_____
Is this condition interfering with work?_____Sleep?_____Routine?_____
Is this condition getting progressively worse?_____
Other doctors seen for this condition?_____
What activities **relieve** your condition/pain?_____
Any home remedies?_____

Other Symptoms (present or past)

- o Headaches
- o Fainting
- o Loss of smell
- o Loss of taste
- o Loss of balance
- o Dizziness
- o Cold sweats
- o Loos of memory
- o Ringing in ears
- o Light sensitivity
- o Face flushed
- o Neck pain
- o Stiff neck
- o Cold hands
- o Grinding teeth
- o Pins & needles in arms
- o Other:_____
- o Numbness in fingers
- o Arm/elbow/hand pain
- o Back problems
- o Pins & needles in legs
- o Knee/leg/foot pain
- o Numbness in toes
- o Cold feet
- o Irritability
- o Depression
- o Nervousness
- o Chest pain
- o Tension
- o Fatigue
- o Shortness of breath sleeping problems
- o Constipation
- o Diarrhea
- o Stomach upset
- o Bowel
- o Bladder
- o Heart
- o Lung
- o Thyroid
- o Liver
- o Gallbladder
- o Endocrine
- o Vision
- o Fever

Personal History

Have you ever had a chiropractic adjustment before? If yes, when was your last visit?

_____

How long were you under care? _____How often did you go?_____

If you stopped, why?_____

Have you ever participated in: (check all that apply)

- ○ Massage
- ○ Meditation
- ○ Breathwork
- ○ Yoga
- ○ Exercise
- ○ Psychotherapy
- ○ Other:_____

Are you currently taking any medications, vitamins, herbs or supplements?

_____

Is there a family history of

	Spinal Conditions	Arthritis	Cancer	Diabetes	Other:_____
Mother's side	○	○	○	○	○
Father's side	○	○	○	○	○

Yes	No	
○	○	Were you taught proper spinal movement?
○	○	Did/do you smoke or drink alcohol?
○	○	Do you eat healthfully?
○	○	Have you been in any accidents?
○	○	Have you had any surgery?
○	○	Are you taking any medications?
○	○	Do you have any history of injury or trauma?
○	○	Were you ever hospitalized?
○	○	Have you ever broken any bones?
○	○	Do you have any dental problems?
○	○	Do you have any hearing problems?
○	○	Do you have any occupational, physical or mental stress?
○	○	Do you have any hobbies or play any sports?

I hereby authorize the doctor's office to care for my condition, as they deem appropriate through Chiropractic procedures. The doctor's office will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

_____ _____

Patient's Signature (Parent of Legal Guardian) Date

_____

Doctor's Signature

Dr. Christopher Singh, DC, MS 151-05 Cross Island Parkway Unit 2, Whitestone, NY 11357

Dr. Christopher Singh, DC, MS

151-05 Cross Island Parkway Unit 2
Whitestone, NY 11357

Terms of Acceptance

In order to provide for the most effective healing environment, the most effective application of chiropractic procedures and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic.

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from the normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is safe, effective procedure applied over one-million times each day by doctors of chiropractic in the United States alone.
D. A through chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If, during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for the care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc.., is essential to maximum healing and optimal health through chiropractic.
G. We often do not know exactly what your insurance company will pay until you receive payment. Please understand that your insurance is an agreement between you and your insurance company and all services rendered to you are ultimately your responsibility.
H. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration or cost in what we work to maintain as a supporting, open environment.

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 satisfaction. I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

Informed Consent For Chiropractic Care

All hospitals and most health care physicians now require informed consent forms to be completed to make patients aware of all the factors related to treatment. We take the same approach in our office. Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc conditions, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care in this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist use in determining if chiropractic care is needed, or if any further examinations or studies are needed before treatment. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral; to another health care provider. All relevant findings will be reported to you along with a care plan to help you become healthier prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

_____	_____
Patient Name (printed)	Relationship to patient
_____	_____
Patient or Legal Guardian Signature	Date
_____	_____
Witness Signature (office staff)	Date