## CONFIDENTIAL REGISTRATION

Date: ______________________________

Last Name: __________________________________ First Name: ______________________

Address: ______________________________________________________________________

City: ______________________ State: _________ Zip Code: _____________

Home Phone: __________________________ Work Phone: __________________________

Cell Phone: ____________________________ E-mail Address: ________________________

Emergency Contact: _____________________ Emergency Phone:_______________________

Employer Name : _______________________________________________________________

Address: _______________________________________________________________

Date of Birth: ___________________________ S.S.#: _________________________________

Gender: M F Marital Status: ____________ Referred By: ____________________________

Is condition related to: Illness Employment Auto Other______________ N/A

Date of Accident (if applicable): ___________________________________________________

Insurance Company Name: ______________________________________________________

Address: ______________________________________________________

Phone #: _______________ Group#: ____________ I.D.#:______________

Name of Insured: ___________________________ Relationship to Insured:______________

Does your insurance company require a referral from your primary physician? ______________

Name and phone number of primary care physician: ___________________________________

Do you have secondary insurance coverage? ____ Name of Company:____________________

Spouse's Name: __________________________ Birthdate: ____________________________

## PATIENT AGREEMENT

I, the undersigned have insurance coverage, with ______________________________, and assigned directly to Dr. Coyne all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I realize that insurance assignment is a courtesy extended by the doctors and that I am ultimately responsible for payment of all services rendered if the insurance company denies payment to the office.

Signature: ______________________________________________ Date: __________________________

*DR. ELLEN COYNE, D.C., FACC 230 West 79 Street (Ste. 123N), New York, NY 10024 (212) 875 - 9780*

# CHIROPRACTIC HEALTH QUESTIONNAIRE

Date____________________

Patient name________________________________________ Birthdate____________________

Reason for visit______________________________________________________

Have you been treated before for this problem? ☐ No ☐ Yes

If yes, by ☐ Physician ☐ Doctor of Chiropractic ☐ Physical Therapist ☐ Osteopath ☐ Other____________

What did they do and/or recommend?________________________________________

When did your symptoms appear?____________ Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Is it constant or does it come and go?_________ Does it interfere with your ☐ Work ☐ Sleep ☐ Daily routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Walking ☐ Bending ☐ Lying down

☐ Other______________________________________________________

Your Occupation______________________________________________________
(Describe activities – sitting, lifting, etc.)

Have you ever had chiropractic care for other problems? ☐ No ☐ Yes ☐ When?________________

Do you take ☐ Muscle relaxers ☐ Pain killers ☐ Insulin ☐ Birth control pills ☐ Over-the-counter meds

☐ Other prescription drugs________________________ Please list all medication in the space at bottom of page.

Date of last: Physical exam____________ Spinal x-ray____________ Blood test____________

Spinal exam____________ Chest x-ray____________ Urine test____________

Dental x-ray____________ MRI, CT-scan, bone scan________________________

Sleep_______ hrs/night Do you sleep on your ☐ Back ☐ Side ☐ Stomach Non-job exercise_______ hrs/wk

Age of mattress______________ or waterbed______________ Is your bed comfortable? ☐ No ☐ Yes

What kind of pillow do you use? ☐ Thick ☐ Medium ☐ Thin ☐ None ☐ Support

Do you wear ☐ Heel lifts ☐ Shoe lifts ☐ Arch supports ☐ Orthotics, describe________________

**CONDITIONS** Check (✓) conditions you have or have had in the past.

| | | | |
|---|---|---|---|
| ☐ AIDS | ☐ Diabetes | ☐ Liver disease | ☐ Rheumatic fever |
| ☐ Alcoholism | ☐ Emphysema | ☐ Measles | ☐ Scarlet fever |
| ☐ Anemia | ☐ Epilepsy | ☐ Migraine headaches | ☐ Stroke |
| ☐ Anorexia | ☐ Fractures | ☐ Miscarriage | ☐ Suicide attempt |
| ☐ Appendicitis | ☐ Glaucoma | ☐ Mononucleosis | ☐ Thyroid problems |
| ☐ Arthritis | ☐ Goiter | ☐ Multiple sclerosis | ☐ Tonsillitis |
| ☐ Asthma | ☐ Gonorrhea | ☐ Mumps | ☐ Tuberculosis |
| ☐ Bleeding disorders | ☐ Gout | ☐ Osteoporosis | ☐ Tumors, growths |
| ☐ Breast lump | ☐ Heart disease | ☐ Pacemaker | ☐ Typhoid fever |
| ☐ Bronchitis | ☐ Hepatitis | ☐ Pneumonia | ☐ Ulcers |
| ☐ Bulimia | ☐ Hernia | ☐ Polio | ☐ Vaginal infections |
| ☐ Cancer | ☐ Herpes | ☐ Prostate problem | ☐ Venereal disease |
| ☐ Cataracts | ☐ High cholesterol | ☐ Prosthesis | ☐ Whooping cough |
| ☐ Chemical dependency | ☐ HIV positive | ☐ Psychiatric care | ☐ Other________ |
| ☐ Chicken pox | ☐ Kidney disease | ☐ Rheumatoid arthritis | __________ |

| **MEDICATIONS** List medications you are currently taking | **VITAMINS/HERBS/MINERALS** |
|---|---|
| | |
| | |
| | |
| Allergies____________________ | |
| Pharmacy Name________________ Phone____________ | |

(OVER)

## GENERAL SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

### GENERAL
- ☐ Bruise easily
- ☐ Chills
- ☐ Dental problems
- ☐ Depression
- ☐ Difficulty sleeping
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐ Tiredness
- ☐ Weight gain

### GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

### GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

### CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

### EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – flashes
- ☐ Vision – halos

### SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

### MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

### WOMEN only
- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period__________

Date of last Pap Smear__________

Have you had a mammogram?__________

Are you pregnant?__________

Number of children__________

## NECK, BACK, EXTREMITIES Check (✓) symptoms you currently have or have had in the past year.

### NECK
- ☐ Pain in neck
- ☐ Neck stiffness
- ☐ Neck weakness
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding/popping sounds in neck

### SHOULDERS

| SHOULDERS | Right | Left |
|---|---|---|
| ☐ Pain in shoulder joint | ☐ R | ☐ L |
| ☐ Pain across shoulders | | |
| ☐ Can't raise arm | ☐ R | ☐ L |
| ☐ Above shoulder level | | |
| ☐ Over head | | |
| ☐ Tension in shoulders | | |
| ☐ Pinched nerve in shoulder | ☐ R | ☐ L |

### MID-BACK
- ☐ Mid-back pain
- ☐ Mid-back stiffness
- ☐ Pain between shoulder blades
- ☐ Pain from front to back
- ☐ Muscle spasms in mid-back

### ARMS & HANDS

| ARMS & HANDS | Right | Left |
|---|---|---|
| ☐ Pain in upper arm | ☐ R | ☐ L |
| ☐ Pain in elbow | ☐ R | ☐ L |
| ☐ Pain in forearm | ☐ R | ☐ L |
| ☐ Pain in hand | ☐ R | ☐ L |
| ☐ Pain in fingers | ☐ R | ☐ L |
| ☐ Pins & needles in arm | ☐ R | ☐ L |
| ☐ Pins & needles in fingers | ☐ R | ☐ L |
| ☐ Numbness in arm | ☐ R | ☐ L |
| ☐ Numbness in fingers | ☐ R | ☐ L |
| ☐ Weakness of arm | ☐ R | ☐ L |
| ☐ Weakness of hand | ☐ R | ☐ L |
| ☐ Hands cold | ☐ R | ☐ L |

### LOW BACK
- ☐ Low back pain
- ☐ Low back stiffness
- ☐ Low back weakness
- ☐ Pinched nerve in low back
- ☐ Low back feels out of place
- ☐ Muscle spasms in low back

### HIPS, LEGS & FEET

| HIPS, LEGS & FEET | Right | Left |
|---|---|---|
| ☐ Pain in buttocks | ☐ R | ☐ L |
| ☐ Pain in hip joint | ☐ R | ☐ L |
| ☐ Pain down leg | ☐ R | ☐ L |
| ☐ Pain in knee | ☐ R | ☐ L |
| ☐ Pain in ankle | ☐ R | ☐ L |
| ☐ Pain in foot | ☐ R | ☐ L |
| ☐ Weakness of leg | ☐ R | ☐ L |
| ☐ Weakness of knee | ☐ R | ☐ L |
| ☐ Leg cramps | ☐ R | ☐ L |

### OTHER SYMPTOMS

______________________________

______________________________

______________________________

______________________________

______________________________

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

______________________________ Patient Signature    ______________ Date

Reviewed by______________________________ Doctor    ______________ Date

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