

# Corning Chiropractic Associates

Carmine Nicastro, DC ~ Denise Nicastro, DC ~ David Kartzman, DC

Name: \_\_\_\_\_ Date: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Home Address: \_\_\_\_\_ Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

SS#: \_\_\_\_\_ Patient Home#: \_\_\_\_\_ Patient Cell #: \_\_\_\_\_

Would you like to receive appointment text message reminders? Y/ N Cell Carrier: \_\_\_\_\_

Would you like to be on our office e-mail list for our health topic of the month, updates, & closing notices? Y/ N

Email: \_\_\_\_\_ Gender: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact's Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

Please list up to 5 important activities that you are having trouble performing because of your spinal condition?  
(i.e. bending to put on your socks, training for a marathon)

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

4) \_\_\_\_\_

5) \_\_\_\_\_

How did it occur? \_\_\_\_\_ Date condition began: \_\_\_\_\_

Did you file a claim for Workers' Comp? Y/N Did you file a claim for a motor vehicle accident? Y/N

Have you tried: Heat - Y/N Ice - Y/N Home Exercise - Y/N Rest - Y/N Medication - Y/N

Have you seen any doctors for this condition? Y/N If yes, who? \_\_\_\_\_ X-ray/MRI/CT/Bone Density \_\_\_\_\_

Have you had this or a similar condition before? Y/N \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Have you had: Back/Neck Surgery - Y/N If yes, when? \_\_\_\_\_ Mammogram - Y/N \_\_\_\_\_ Colonoscopy - Y/N \_\_\_\_\_

Prior Chiropractic Care - Y/N \_\_\_\_\_ Pneumonia Vaccination - Y/N Influenza Immunization - Y/N

Tested + for COVID-19? - Y/N If yes, when: \_\_\_\_\_ COVID Vaccine - Y/N If yes, when and type: \_\_\_\_\_

Please list any medications that you are currently on (ie. Blood Thinners, Cortisone, Oral Contraceptives, etc.):

\_\_\_\_\_ Birth Control - Y/N If yes, type: \_\_\_\_\_

Important Family History: \_\_\_\_\_

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Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please fill out this Health History to the best of your knowledge!

**Do you have or have a history of having:**

- New Loss of Taste or Smell
- Anemia/Bruise Easily
- Anxiety/ Depression
- Appendix or Gallbladder Removal
- Arthritis\_\_\_\_\_
- Asthma/Pneumonia/COPD
- Autoimmune Disorders/Rheumatoid Arthritis
- Bleeding Disorders/Blood Clots
- Cancer\_\_\_\_\_
- Carpal Tunnel Syndrome/Surgery
- Chest Pain with Exertion/Angina
- Diabetes/Pump/Neuropathy
- Difficulty Swallowing
- Dizziness/Vertigo/Loss of Balance/Gait Changes
- Eating Disorder/Change in Appetite
- Fibromyalgia/Chronic Fatigue Syndrome
- Fracture\_\_\_\_\_
- Headaches\_\_\_\_\_
- Heart Attack/Heart Surgeries \_\_\_\_\_
- High Blood Pressure/Cholesterol
- Hysterectomy\_\_\_\_\_
- Joint Replacement/Orthopedic Surgery
- Kidney/Liver Disease\_\_\_\_\_
- Lyme Disease/Tick Exposure\_\_\_\_\_
- Mononucleosis
- Multiple Sclerosis/Parkinson's Disease
- Osteoporosis/Bone Density\_\_\_\_\_
- Pacemaker/Irregular Heart Beat
- Plantar Fascitis/Orthotics
- Reflux/GERD
- Scoliosis
- Seizure/Epilepsy
- Shingles/Mole Changes
- Slurred Speech/Facial Numbness/TMJ
- Sleep Apnea/CPAP Machine
- Stroke/TIA
- Thyroid Disease
- Vitamin Deficiency: D/B12

**Within the past month until now:**

- Unexplained Weight Loss
- Night Sweats
- Bowel Change/Blood/Dark Stools
- Change in Headache
- Chest Pain/Short of Breath
- Fever or Infection
- Nausea /Vomiting/Abdominal Pain
- Unable to Urinate/UTI/Blood/Burning/Odor

**Smoke:** Y/N **Alcohol:** Y/N **Females-Pregnant:** Y/N

**Outdoor Activities:** Y/N Type\_\_\_\_\_

It is our goal that you receive care from our office which will meet your expectations. Our doctors will take a history and perform an examination relevant to your condition. In some cases we will recommend imaging such as x-rays or MRIs. We also may need to refer you to a medical physician or another form of care. We will attempt to offer you an explanation of your condition. We encourage you to ask questions during your visit or to call our office. While chiropractic care is generally accepted to be safe and effective, certain questions regarding risks have been raised. It is our intent to be able to provide information and answers to any questions you may have. By signing below you agree to the Informed consent and the Notice of Privacy Practices.

**Informed Consent:** I understand and am informed that, as in all healthcare, in the practice of chiropractic there are some rare risks to treatment, including but not limited to muscle strains and sprains, fractures, dislocations, disc injuries and stroke.

**HIPAA:** I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that these privacy practices will be followed by Corning Chiropractic Associates to ensure the privacy of my personal health information. I understand that this form will be placed in my patient chart and maintained for six years.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dr. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

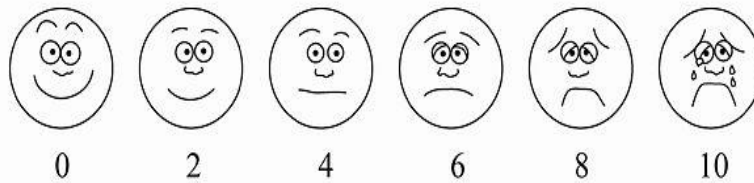
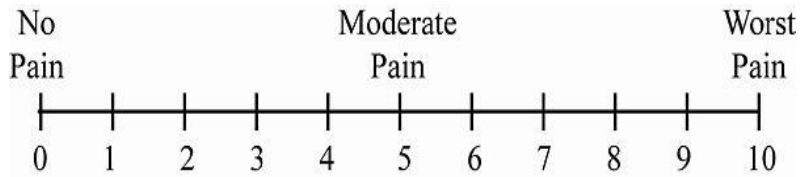
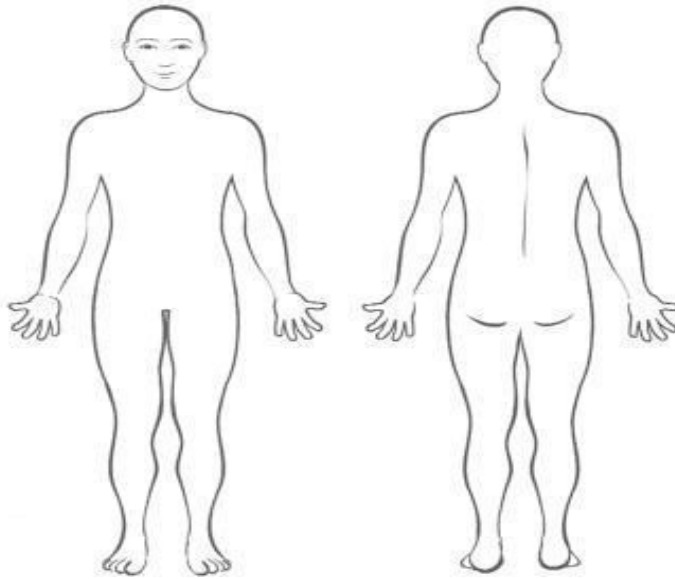
# *Corning Chiropractic Associates*

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*Welcome and thank you for choosing our office.*

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Please complete the pain diagram and rate your pain:



Patient Signature: \_\_\_\_\_

Doctor Signature: \_\_\_\_\_