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:_____

75 West Pulteney St. Corning, NY 14830 | Phone: (607)962-3387 | Fax: (607)937-3674
Email: CorningChiro98@gmail.com | www.corningchiropractic.com

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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 Fatique 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:_____

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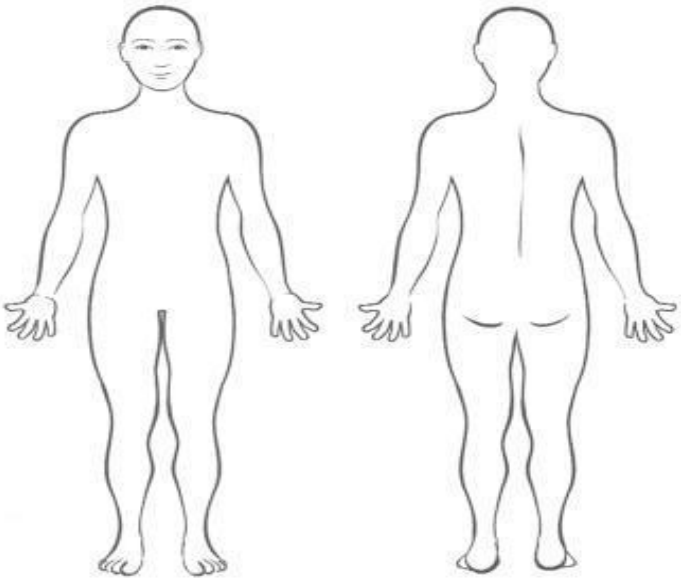
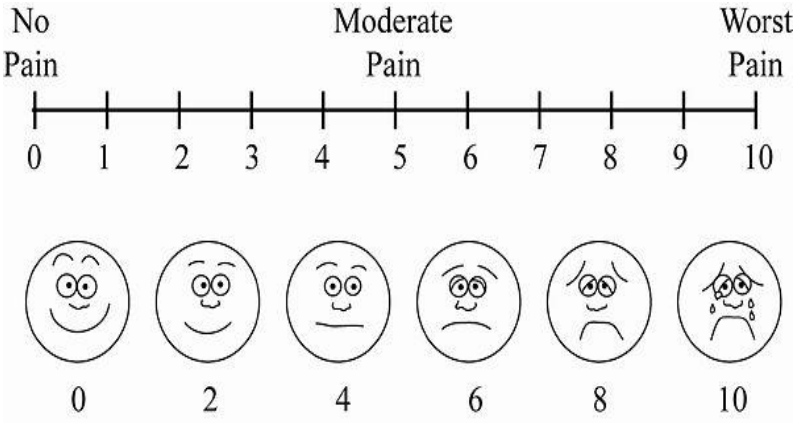
Welcome and thank you for choosing our office.

Name:_____ DOB:_____ Date:_____

Please complete the pain diagram and rate your pain:





Patient Signature:_____ Date:_____
Dr. Signature:_____ Date:_____

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