Patient Intake Form

Please fill in the information as accurately as possible.
Once completed, please email the form to jennifer@pittsfordperformancecare.com

1. Please complete the following information:

Name (Enter Full Name)	Date of Birth (MM/DD/YYYY)	
Address	City	State
Phone (Parent/Guardian if under 18)	Patient email:	Parent/Guardian Email (if applicable):

2. How did you hear about our clinic?

3. If referred by someone, please name:

4. May we send you clinic updates? ◯ Yes ◯ No

This information may be disclosed to and used by the following individual organization:

Pittsford Performance Care
3800 Monroe Ave, Suite 22
Pittsford, NY 14534

Phone: 585.203.1050
Fax: 585.203.1838

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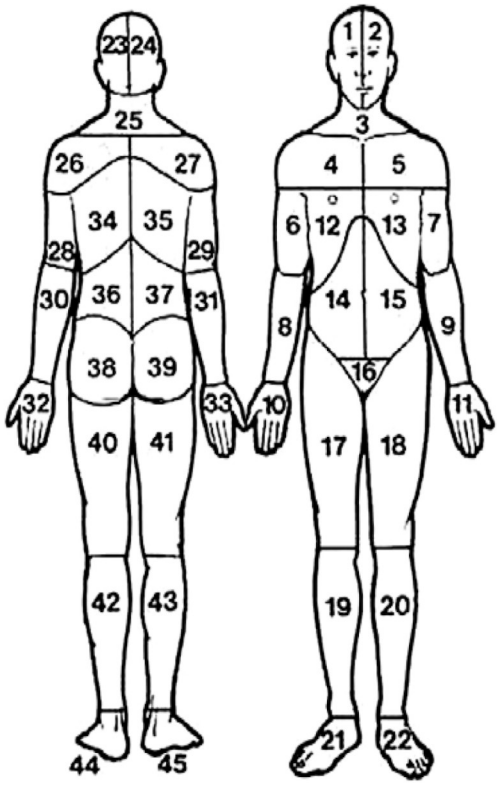
5. Who is Responsible for this bill? Enter Here

I authorize Pittsford Performance Care the release of any medical or other information necessary to process this claim. I request payment of medical benefits from either a government or non-government source to Pittsford Performance Care. I authorize Pittsford Performance Care to initiate a complaint to the Insurance Commissioner on my behalf. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I further understand that I will be legally responsible for all collection costs involved with the collection of this account including court costs, reasonable attorney fees and all other expenses incurred with collections, if I default on this agreement. In addition, if I issue a check that is returned by the bank for non-sufficient funds, I understand I will be charged $30.00 for each returned check. While Pittsford Performance Care will aide in the processing of my non-contract insurance claim, I understand that if my insurance does not pay within 60 days, my account will be determined as self-pay and due in full by myself. I certify the information above is true and correct to the best of my knowledge.

Signature (Enter full name): Enter Full Name Date (MM/DD/YYYY): Enter Date

Chief Complaint – Present Condition

1. When did your complains and / or symptoms begin — Enter here
2. Describe your current injury or your current problem: — Enter here
3. Please number the location of pain according to diagram below — Enter here



Rate your pain right now (mark as "N")

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain Mild Moderate Severe v. Severe

Rate your pain at worst (mark as "W")

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain Mild Moderate Severe v. Severe

Rate your pain at best (mark as "B")

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain Mild Moderate Severe v. Severe

Present Condition Continued

Primary Medical Physician: _____ Phone: _____

Primary Clinic Location: _____

Do you have medical records that have been created or have you seen another doctor because of your current condition? ○ Yes ○ No

If so, please list the doctors that have see you for your current complaint:

1. Name: _____ Phone: _____ City / State: _____
2. Name: _____ Phone: _____ City / State: _____
3. Name: _____ Phone: _____ City / State: _____

Have you had any diagnostic tests performed by the aforementioned doctors or other doctors? If so, select the tests you have performed.

☐ MRI ☐ X-rays ☐ Functional Testing ☐ Psychological Testing ☐ Electrodiagnostics ☐ Lab Work Other: _____

Please feel free to add any additional comments about your condition at this point in time that you feel would be important to your condition:

Present Condition Continued

Have you ever been hospitalized? ○ Yes ○ No

If so, where and when?

Please list your surgeries:

Date (mm/dd/yyyy)	Type of Surgery	Results

Have you ever been hospitalized? ○ Yes ○ No If yes, please complete table below:

Medication Name	Dosage	How Often	Duration of Medication

Are there any medications you have had an allergic reaction or unpleasant side effects?

Are you currently taking any supplements? Yes / No If yes, please complete table below:

Supplement Name	Dosage	How Often	Duration of Supplement

Past Medical History

Systems Review

Please circle any of the following conditions that apply to you, ***past or present***

☐	Osteoporosis	☐	Congenital Heart Disease	☐	Depression
☐	Dislocated bones	☐	Shortness of breath w activity	☐	Prostate problems
☐	Fractured bones	☐	Shortness of breath at rest	☐	Anemia
☐	Bone infection	☐	Fainting spells	☐	Allergies
☐	Herniated disc	☐	Double vision	☐	Anxiety
☐	Scoliosis	☐	Muscle cramping	☐	HPV
☐	Osteoarthritis	☐	Tremors (shaking)	☐	Erectile dysfunction
☐	Rheumatoid arthritis	☐	Eczema	☐	Bleeding disorder
☐	Ankylosing spondylitis	☐	Dyslexia	☐	Breast lumps / soreness
☐	Mental or emotional disorder	☐	Asberger's syndrome	☐	Vascular disease
☐	Learning disability	☐	Sleep apnea	☐	Autoimmune disease
☐	Heart palpitations	☐	Arrhythmia	☐	Panic attacks
☐	Swelling in the legs or feet	☐	Heart murmur	☐	PTSD
☐	Congestive heart failure	☐	Artherosclerosis	☐	OCD
☐	COPD chance of	☐	Asthma	☐	Kidney problems / disease
☐	Hypertension	☐	Celiac disease	☐	Kidney stone
☐	Seizures	☐	Irritable bowel syndrome	☐	Difficulty urinating
☐	Trouble concentrating	☐	Night sweats	☐	Feeling of urgency to urinate
☐	Paralysis	☐	Bruise easy	☐	Leg pain w/ walking
☐	Twitching muscles	☐	Skin cancer	☐	Blood clots
☐	ADD/ADHD	☐	Loss of consciousness	☐	Frequent colds / flu
☐	Macular degeneration	☐	Concussions	☐	Alcoholism
☐	Ringing in ears	☐	Head injury	☐	Cancer
☐	Sinus problems	☐	Autism	☐	Feelings of suicide
☐	Mouth sores	☐	Bed wetting	☐	Eating disorders
☐	Pregnancy	☐	High cholesterol	☐	Blood in urine
☐	Irregular heart beats	☐	Crohn's disease	☐	Painful urination
☐	Experience passing out	☐	Hyperthyroidism	☐	Awaken to urinate
☐	Skipped heart beats	☐	Hypothyroidism	☐	Pregnancy or chance of
☐	Psychological issues	☐	Other Please describe:		

Past Medical History

I hereby authorize physicians and staff at Pittsford Performance Care to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

Chiropractic, as well as other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system we cannot promise a cure for any symptom, condition of disease as a result of treatment with Pittsford Performance Care. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific risk possibilities associated with chiropractic care: *Soreness* – Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. *Soft-Tissue Injury* – Occasionally chiropractic treatment may aggravate a disc injury or cause other minor joint ligament, tendon or other soft-tissue injury. *Rib Injury* – Manual adjusting to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk. *Physical Therapy Burns* – Heat generated by physical therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a staff member. *Stroke* – Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments. *Other problems* – There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

Having carefully read the "Informed Consent" (above), I hereby give my informed consent to have treatment administered.

Patient Signature (Enter full name): _____ Date (mm/dd/yyyy): _____

Patient/Guardian Signature (Enter full name): _____ Date (mm/dd/yyyy): _____

Patient's Right to File a Complaint:

If you believe any of your Privacy Rights have been violated, you can file a written complaint with our Privacy Officer. Your complaint must be filed within 180 days of when you know or should have known that the act occurred. In addition, you can also file a written complaint either of paper or electronically with the Office of Civil Rights. Please note that the privacy law prohibits our office from taking any regulatory actions against you.

I have received a copy of this office's Notice of Privacy Practices and consent to the use and disclosures of protected health information by Pittsford Performance Care for treatment, payment, healthcare operations and additional uses listed above. I have reviewed, acknowledged, understand the content of the Notice of Privacy Practices and have had all my questions answered to my satisfaction.

Patient Signature (Enter full name): _____ Date: _____