

CONFIDENTIAL PATIENT INFORMATION

Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Telephone _____ Age _____ Birthdate _____ Marital Status: M S W D

Work Telephone _____ # Children _____ Spouse's Name _____

Occupation _____ Your E-mail Address _____

Name and Address of Employer _____ Health Administrator's Name _____

HEALTH INFORMATION

Have you had previous chiropractic care? Yes No

Main Complaint _____

Other Complaints _____

Are you pregnant? Yes No

Are you taking any medication? Yes No If yes, what? _____

Sign here to authorize x-rays and necessary tests _____

How long have you had this condition? _____

Have you had similar conditions in the past? _____

Does this condition affect your family or social life? Yes No

What aggravates this condition? _____

Other Doctors seen for this condition _____

What helps your symptoms? _____

Have you had any surgery, falls or accidents? Yes No

When? _____ Please describe _____

Date of last physical examination _____

INSURANCE INFORMATION

Is this condition due to:
 A work-related injury? Yes No An automobile accident? Yes No

If you answer yes to either of the above questions, please complete other side of form.

Do you have Major Medical Health Insurance? Yes No

Company _____

Address _____

Does your insurance company require a referral from your Primary Care Physician? Yes No

If yes, name of PCP _____ Telephone _____

Do You Suffer From:

	YES	NO
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arm or Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hip or Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Palpitation	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory	<input type="checkbox"/>	<input type="checkbox"/>
High or Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Female Problems	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>
Lung or Bronchial Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Digestive Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Loose Stool	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Morning Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Poor Memory	<input type="checkbox"/>	<input type="checkbox"/>
Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dudick Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Dudick Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date: _____

Guardian or Spouse's Signature _____ Date: _____

Information Taken By: _____ Date: _____

Complete only for:

JOB INJURY INFORMATION: Date _____ Time _____ Location _____

Description of accident _____

Workman's Compensation Case # _____

Insurance Company _____ Address _____

Insurance Company Case # _____

Employer's Name _____ Address _____

Hospitalized? _____ Name of Hospital _____ X-rays taken _____

Other Doctors seen _____

Are you working now? _____

Time lost from work _____ to _____ (dates)

Complete only for:

ACCIDENT INFORMATION: Date _____ Time _____ Location _____

How did accident occur? Auto Collision Other _____

If auto accident, were you Driver Passenger Pedestrian

If auto collision, were you struck from Behind Right Side Left Side Front Auto was Parked

Did your car strike the other(s) involved? Yes No

Or did the other car strike yours? Yes No Undetermined

As a result of the accident, were traffic citations issued to you? Yes No

To the driver of the other car? Yes No

To the driver of your car? Yes No

List the extent of the injuries as you know them _____

Did you require post-accident hospitalization? Yes No

Check symptoms you have noticed since accident:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Light Bother Eyes | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Head Seems Too Heavy | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Pins and Needles in Arms | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins and Needles in Legs | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fainting | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> _____ |

Symptoms other than above _____

Have you lost any days of work? Yes No Dates: _____

Insurance Companies involved:

My Company _____

Company of person responsible for injuries _____

Have you been contacted by an insurance adjuster or company representative regarding this claim? Yes No

Do you have an attorney that has advised you in this care? Yes No

Name _____

Address _____

Telephone: _____



RE: Name of Patient _____

D.O.B.: _____

SS # _____

RECORDS RELEASE

1) I hereby authorize Dudick Health to release and to permit the examination or copying of any of my medical records, X-rays, laboratory reports, and the results of all tests of any type or character to such persons as Dudick Health deems appropriate, including the information necessary to process a claim.

2) I hereby authorize my doctor or supplier of service to release and to permit the copying of any of my medical records, X-rays, insurance information, laboratory reports and the results of all tests of any type to Dudick Health, at 1789 Route 9, Clifton Park, NY 12065.

SIGNED _____ DATE _____

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to Dudick Health for services provided.

SIGNED _____ DATE _____

ACCEPTANCE OF PATIENT RESPONSIBILITY

I understand that I am financially responsible for any charges incurred at this office, including copays, deductibles, and charges denied or not covered by my insurance company. I realize my care may be subject to pre-authorization by the insurance company, and I accept any responsibility for charges which may not be approved, including the initial visits while waiting for approval. The insurance company will review any/all documentation submitted by Dudick Health for review for medical necessity and base their approval/denial upon this documentation.

SIGNED _____ DATE _____

Chiropractic Patient Information Form Form 1B

Landmark Healthcare, Inc. 1750 Howe Ave., Suite 300, Sacramento, CA 95825

Practitioner Last Name Judice	First Name Michael	M.I.	License # X008172-1	Phone # (518) 383-5849	Fax # (518) 383-5848
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Patient to complete the following sections:

Patient Last Name	Patient First Name	M.I.	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Age	Date of Birth (MM/DD/YYYY)	
Insured I.D. or SSN	Insured Last Name	M.I.	First Name	Patient Daytime Phone		
Patient Address		City	State	Zip		
Employer Name	Insurance Company	Group Plan # or Union Local				
Is illness or injury related to: <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Other	Do you have other insurance that might cover this injury/illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list other insurance company name:				
Please list your reason(s) for this visit or your condition(s) in order of importance:	Date you first noticed:	Using a scale in which "0" is none (no pain or symptoms) and "10" is severe pain or symptom(s), circle the number that best reflects your condition: ↓ none to severe ↓				Please check the box below that best represents how much of the time you feel pain or your symptom(s) for the listed reason:
		1	0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%		
		2	0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%		
		3	0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%		
4	0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%				

For each of the reasons or conditions listed above, please mark how it happened:

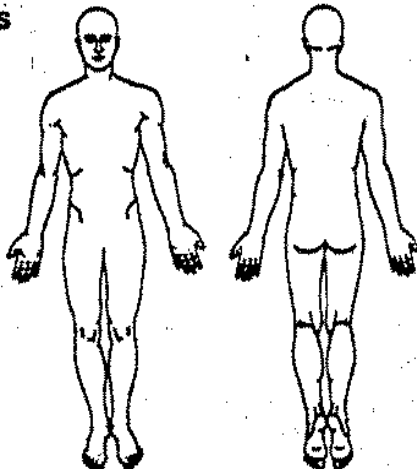
- Developed over time Illness Injury Auto accident Other _____ I don't know
- Developed over time Illness Injury Auto accident Other _____ I don't know
- Developed over time Illness Injury Auto accident Other _____ I don't know
- Developed over time Illness Injury Auto accident Other _____ I don't know

For each reason listed above, please check if it is better or worse with any of the following:

	HEAT		COLD		REST		ACTIVITY		OTHER (please describe on line below)	
	better	worse	better	worse	better	worse	better	worse	better	worse
Reason 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reason 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reason 3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reason 4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please mark the areas of discomfort or pain on the figures to the right using the symbol that best describes the feeling:

- +++ Sharp or stabbing
- ooo Pins and needles
- vvv Dull or aching
- /// Numbness



Please check the box that best describes whether your pain or symptom(s) limit normal activities:

Activity	Normal	Somewhat limited	Severely limited
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resting in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Computer work/typing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Normal work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Household activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreational activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (list below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Chiropractic Patient Information Form Form 1B

Please continue ...

- a. During what time of the day do you feel worse? _____
- b. Do you sleep well? Yes No What are your normal sleeping hours? _____ to _____
- c. Are you currently under the care of a medical doctor or other type of health care provider for any condition?
 No Yes → For what condition? _____
Name of doctor/provider _____ Phone number _____
- d. Have you ever had an overnight stay in a hospital or a surgical procedure of any kind?
 No Yes If yes, please describe each event below:
Event _____ Year _____
Event _____ Year _____
- e. Do you exercise? Yes No If yes, please describe activity _____
How many days a week? _____ How many minutes per session? _____

Personal history

The following lists a variety of conditions that patients may experience. Please read through the list and check the box next to each condition that applies to you.

Pain in body

- | | | |
|---|---|--|
| <input type="checkbox"/> Neck pain with difficulty swallowing | <input type="checkbox"/> Recent progressive muscle weakness or shaking | <input type="checkbox"/> Severe degenerative arthritis |
| <input type="checkbox"/> Extreme neck stiffness with pain or electric shocks in arms or legs when moving neck | <input type="checkbox"/> Recent or current fever over 102°F | <input type="checkbox"/> History of compression fracture |
| <input type="checkbox"/> Leg pain that worsens with exercise but is relieved by resting | <input type="checkbox"/> Loss of bowel or bladder control | <input type="checkbox"/> History of heart attack |
| <input type="checkbox"/> Loss of feeling in inner thighs | <input type="checkbox"/> Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions | <input type="checkbox"/> History of stroke or aneurysm |
| <input type="checkbox"/> Back pain with urinary problems | <input type="checkbox"/> Recent major accident such as a fall from height, whiplash or blow to the head | <input type="checkbox"/> Past history of cancer or currently diagnosed with cancer |
| Types of pain | <input type="checkbox"/> Memory loss after injury | <input type="checkbox"/> Diabetes with cold, burning or numb feet |
| <input type="checkbox"/> Severe pain interrupts sleep | Previously diagnosed condition/ medical history | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Constant pain that doesn't improve by changing positions or lying down | <input type="checkbox"/> Congenital bone or joint disorder | <input type="checkbox"/> Lupus |
| Current conditions | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Ankylosing spondylitis |
| <input type="checkbox"/> Unable to balance when walking | | <input type="checkbox"/> Immune suppression such as from chemotherapy, organ transplant, etc. |
| <input type="checkbox"/> Recent unexplained weight loss | | <input type="checkbox"/> 3 or more months use of steroid medications or intravenous drugs (past or recent) |

Family history

- | | | | |
|---|-----------------------------------|---|---|
| <input type="checkbox"/> Autoimmune disorders | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Seizure disorder |

I certify that the above information is true and correct to the best of my knowledge and I hereby consent to the release of my confidential medical and patient information in the possession of the practitioner named above to other health professionals to whom I am referred and to the insurance company or other entity responsible for payment, utilization and/or quality review for all or a portion of my care.

Signature _____ Today's date: ____/____/____

If patient required assistance to complete, sign name and state relationship (i.e., parent, translator) below:

Name _____ Relationship _____ Today's date: ____/____/____