

DUKE CHIROPRACTIC

MULTISPORT SPINE & JOINT REHABILITATION

9 East 38th Street, 9th Floor, New York, NY 10016

(212) 481.0066

www.dukechironyc.com



**DUKE
CHIROPRACTIC**
MULTISPORT SPINE & JOINT
REHABILITATION

IDENTIFICATION DATA

Name				Today's Date		/	/
Address				City/State/Zip			
Age				Date of Birth		/	/
Home Phone () -				Mobile Phone () -			
Email				Emergency Contact () -			
Marital Status		M	S	D	W	Number of Children	
Profession				Business Phone () -			
Who referred you to us today?							

CURRENT HEALTH

What is your main complaint today? _____

How long have you had this complaint? _____

Is your current complaint related to a **work** or **auto** related accident? Please Explain: _____

How bad is your pain today?

MIN											MAX
	1	2	3	4	5	6	7	8	9	10	

Please describe the character of your pain (please check any and all that apply):

Sharp	Shooting	Dull	Gripping/Constricting	Numb	Tingling	Deep
Stabbing	Aching	Sore	Throbbing/Gnawing	Weak	Annoying	Burning

How often are these symptoms present? **Occasional** **Frequent** **Constant**Since your pain began has it: **Increased** **Decreased** **Stayed the Same**Do you have any **swelling** or **bruising** at the site of your pain?What makes your pain better: **Nothing** **Lying Down** **Walking** **Standing** **Movement**What makes your pain worse? **Nothing** **Lying Down** **Walking** **Standing** **Movement**

What type of exercise or physical activity do you presently do on a regular basis? _____

How is your general stress level? **Mild** **Moderate** **Extreme**Nutritional Status **Poor** **Good** **Excellent****PRIMARY CARE PROVIDER**

Name of your Primary Care Provider: _____ PCP Phone: _____

PREGNANCYAre you Pregnant? **Yes** **No** If so how far along? _____Pregnancy History/Number of Children: _____ C-SECTIONS **Yes** **No** Date(s): _____**DUKE CHIROPRACTIC**

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Dr. Scott G. Duke, D.C.
Dr. Peter J. Duggan, D.C.
Dr. Nicholas F. Amico, D.C.

TREATMENT

Have you received any treatment for your condition? If yes, when and by whom? _____

Have you received any of the following for your condition? Please check any and all that apply:

Physical Therapy Chiropractic Massage Acupuncture Botox Facet Block Surgery Epidural Injection

Have you had any of the following imaging done?

X-RAY

MRI

CT SCAN

ULTRASOUND

Dates images were taken and of what areas of the body? _____

PERSONAL HEALTH HISTORY

<ul style="list-style-type: none"> <input type="checkbox"/> Abnormal Weight gain or loss <input type="checkbox"/> Allergies <input type="checkbox"/> Anorexia <input type="checkbox"/> Arthritis <input type="checkbox"/> Blood Clots <input type="checkbox"/> Breast Implants Date: _____ <input type="checkbox"/> Cancer/Tumors <input type="checkbox"/> Corticosteroid Use <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Disk Injuries <input type="checkbox"/> Dizziness/Fainting <input type="checkbox"/> Epilepsy/Seizures <input type="checkbox"/> Headaches <input type="checkbox"/> Heart Problems <input type="checkbox"/> HIV/AIDS 	<ul style="list-style-type: none"> <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Menstrual Problems <input type="checkbox"/> Migraines <input type="checkbox"/> Morning Pain or Stiffness <input type="checkbox"/> Muscular In-Coordination <input type="checkbox"/> Muscular/Tissue Tears <input type="checkbox"/> Night Pain <input type="checkbox"/> Numbness in Buttocks/Groin <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Phlebitis <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Rapid Heart Beat <input type="checkbox"/> Recent Fever <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Scoliosis <input type="checkbox"/> Stroke 	<ul style="list-style-type: none"> <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Urinary Problems <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Visual Disturbances <input type="checkbox"/> Other: _____ <p>Family History</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Problems <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Stroke 	<p>Hospitalizations:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Medications/Vitamins:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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PLEASE INDICATE THE AREA(S) IN WHICH YOU ARE EXPERIENCING PAIN OR DISCOMFORT



I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to contact my physician, if necessary.

Patient/Guardian Signature _____