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OPTIMUM HEALTH THROUGH CHIROPRACTICE CARE

PATIENT INFORMATION

Please Print

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Name _____ Date _____ SSN: _____ - _____ - _____
First MI Last

Address _____ City _____ State _____ Zip _____

Sex _____ Female _____ Male

Birth date _____ Home phone _____ Work phone _____

Do you prefer to receive calls at: _____ Home _____ Work _____ Either

Are you: _____ Minor _____ Married _____ Divorced _____ Widowed _____ Single _____ Separated

Your employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Workplace _____ Work Phone _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone _____

RESPONSIBLE PARTY

Name of person responsible for this account _____

Relationship to patient _____ Phone _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Work phone _____

INSURANCE INFORMATION

Name of insured _____ Relationship to patient _____

Birth date _____ SSN _____ - _____ - _____ Date employed _____

Name of employer _____ Work phone _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Phone _____ Group # _____ Employer # _____

Insurance Co. address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual benefit? _____

DO YOU HAVE ADDITIONAL INSURANCE _____ YES _____ NO?

(IF YES, PLEASE COMPLETE THE FOLLOWING)

Name of insured _____ Relationship to patient _____

Birth date _____ SSN _____ - _____ - _____ Date employed _____

Name of employer _____ Work phone _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Phone _____ Group # _____ Employer # _____

Insurance Co. address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual benefit? _____

MEDICAL HISTORY

Print the names of your relatives, living or deceased, in the list at the left. Place an (x) in the appropriate column for any illnesses that you or the relatives listed at the left have had.

Your Illness	Allergies	Anemia	Arthritis	Asthma	Bleeding	Cancer	Convulsions	Diabetes	Drinking	Drug Problems	Eczema	Emphysema	Heart Trouble	Hepatitis	High Blood Pressure	Freq. Infections	Kidney Problems	Mental Illness	Migraines	Abnormal Period	Psoriasis	Pneumonia	Polio	Prostate	Rheumatic Fever	Stomach Problems	Stroke	Thyroid Problems
Father																												
Mother																												
Brothers/sisters																												
Children																												
Grandparents																												

If needed, comment on any of the above:

If you have had any of the following tests or immunizations, place an (X) in the appropriate box, and if you can, give the year you last had them:

YEAR	TESTS	YEAR	IMMUNIZATIONS
_____	() Chest X-ray	_____	() Smallpox
_____	() Kidney X-ray (pyelogram)	_____	() Tetanus
_____	() G I Series	_____	() Polio
_____	() Colon X-Ray (Barium enema)	_____	() Typhoid
_____	() Gallbladder X-ray (Cholecystogram)	_____	() Flu

Have you ever had:

- lapse of consciousness
- convulsions
- shock
- stroke
- high blood pressure
- heart attack
- diabetes
- arthritis
- emphysema
- pneumonia
- history of allergy

Hospitalizations:
when where reason

GASTROINTESTINAL/DIGESTIVE

Check what applies to you:

- | | | |
|--|---|--|
| <input type="checkbox"/> heartburn | <input type="checkbox"/> queasy stomach | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> indigestion | <input type="checkbox"/> freq. nausea | <input type="checkbox"/> belch freq. |
| <input type="checkbox"/> freq. vomiting | <input type="checkbox"/> bloody stools | <input type="checkbox"/> ulcer |
| <input type="checkbox"/> flatulence | <input type="checkbox"/> bloating | <input type="checkbox"/> anal itching |
| <input type="checkbox"/> cramping | <input type="checkbox"/> stomachaches | <input type="checkbox"/> poor appetite |
| <input type="checkbox"/> picky eater | <input type="checkbox"/> rectal bleeding | <input type="checkbox"/> constipated |
| <input type="checkbox"/> stool/foul odor | <input type="checkbox"/> gallbladder trble. | <input type="checkbox"/> anal pain |
| <input type="checkbox"/> mucous colitis | <input type="checkbox"/> on special diet | <input type="checkbox"/> burning stomach eating relieves |
| <input type="checkbox"/> mucous in stool | <input type="checkbox"/> good appetite | <input type="checkbox"/> diarrhea |

URINARY AND GENITALIA

Check what applies to you:

- | | | |
|--|---|---|
| <input type="checkbox"/> freq. urination | <input type="checkbox"/> painful urination | <input type="checkbox"/> burning |
| <input type="checkbox"/> bedwetting | <input type="checkbox"/> itching | <input type="checkbox"/> cystitis |
| <input type="checkbox"/> kidney stones | <input type="checkbox"/> bladder disease | <input type="checkbox"/> weak stream |
| <input type="checkbox"/> kidney disease | <input type="checkbox"/> being treated for inf. | <input type="checkbox"/> pass blood |
| <input type="checkbox"/> prostate trble. | <input type="checkbox"/> lumps, pain, swell, in testicles | <input type="checkbox"/> sores |
| <input type="checkbox"/> have yeast inf. | <input type="checkbox"/> difficulty starting urination | <input type="checkbox"/> genital herpes |
| <input type="checkbox"/> spouse being trtd | <input type="checkbox"/> had or have cancer | <input type="checkbox"/> being treated for trich. |
| For trichomonas | | <input type="checkbox"/> satisfactory sexual |
| <input type="checkbox"/> being treated for yeast | | relations |

EYES

Check or list every symptom you have if your eyes trouble you:

- | | | |
|------------------------------------|---|---|
| <input type="checkbox"/> itching | <input type="checkbox"/> styes | <input type="checkbox"/> blurred vision |
| <input type="checkbox"/> irritated | <input type="checkbox"/> crusty lids | <input type="checkbox"/> bloodshot |
| <input type="checkbox"/> watering | <input type="checkbox"/> granulated lids | <input type="checkbox"/> mucous in eyes |
| <input type="checkbox"/> dryness | <input type="checkbox"/> twitching lids | <input type="checkbox"/> dark circles |
| <input type="checkbox"/> burning | <input type="checkbox"/> swelling both lids | <input type="checkbox"/> sensitive to light |
| <input type="checkbox"/> pain | <input type="checkbox"/> puffy under eyes | <input type="checkbox"/> sensitive to dark |
| <input type="checkbox"/> cataracts | <input type="checkbox"/> glaucoma | <input type="checkbox"/> wear glasses |
| <input type="checkbox"/> see halos | <input type="checkbox"/> wear contacts | <input type="checkbox"/> double vision |

Are your eye symptoms present all year round? yes no

What is your worst season? _____

EARS

Please check or list every symptom that applies to your ears:

- | | |
|---|---|
| <input type="checkbox"/> hearing loss | <input type="checkbox"/> "floating sensation" |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> ever lanced |
| <input type="checkbox"/> itching inside | <input type="checkbox"/> sense of imbalance |

- | | |
|--|--|
| <input type="checkbox"/> crusting inside | <input type="checkbox"/> frequent infections |
| <input type="checkbox"/> serous otitis | <input type="checkbox"/> ears stuffed up |
| <input type="checkbox"/> hearing aid | <input type="checkbox"/> nerve deafness |
| <input type="checkbox"/> drainage | <input type="checkbox"/> tubes in ears |
| <input type="checkbox"/> pressure | <input type="checkbox"/> ringing/ roaring |
| <input type="checkbox"/> pain | <input type="checkbox"/> other |

NOSE

Check every symptom that applies to your nose (to a greater than normal degree)

- | | | |
|--|---|--|
| <input type="checkbox"/> itches | <input type="checkbox"/> bleeds | <input type="checkbox"/> sinus infections |
| <input type="checkbox"/> blocks | <input type="checkbox"/> crusts | <input type="checkbox"/> post nasal drip |
| <input type="checkbox"/> burns | <input type="checkbox"/> require nose drops/spray | <input type="checkbox"/> mucous yellow |
| <input type="checkbox"/> sneeze | <input type="checkbox"/> runs | <input type="checkbox"/> mucous blood streaked |
| <input type="checkbox"/> no sense of smell | <input type="checkbox"/> other | <input type="checkbox"/> polyps |

Are these symptoms present all year round? yes no

What is your worst season? _____

Symptoms are worse:

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> upon arising | <input type="checkbox"/> after meals | <input type="checkbox"/> after medication |
| <input type="checkbox"/> at night | <input type="checkbox"/> upon lying down | <input type="checkbox"/> cold |
| <input type="checkbox"/> hot | <input type="checkbox"/> humid | <input type="checkbox"/> dry |

MOUTH AND THROAT

Please check every symptom that applies to you:

- | | | |
|--|---|--|
| <input type="checkbox"/> snore | <input type="checkbox"/> sleep mouth open | <input type="checkbox"/> difficulty swallowing |
| <input type="checkbox"/> hoarse | <input type="checkbox"/> canker sores | <input type="checkbox"/> lips crack/ corners |
| <input type="checkbox"/> bad breath | <input type="checkbox"/> tongue swollen | <input type="checkbox"/> throat itches |
| <input type="checkbox"/> bad taste | <input type="checkbox"/> throat clearing | <input type="checkbox"/> neck glands swell |
| <input type="checkbox"/> lips swell | <input type="checkbox"/> wear dentures | <input type="checkbox"/> grind teeth in sleep |
| <input type="checkbox"/> chapped lips | <input type="checkbox"/> post nasal drip | <input type="checkbox"/> fever blisters |
| <input type="checkbox"/> sore throats | <input type="checkbox"/> hoarseness | <input type="checkbox"/> sore/ raw tongue |
| <input type="checkbox"/> throat closed | <input type="checkbox"/> other | |

CARDIAC AND RESPIRATORY

Please check or list any chest symptoms you have now or have had in the past:

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> wheeze | <input type="checkbox"/> frequent coughs | <input type="checkbox"/> frequent infections |
| <input type="checkbox"/> asthma | <input type="checkbox"/> cough mucous | <input type="checkbox"/> pneumonia ___ times |
| <input type="checkbox"/> bronchitis | <input type="checkbox"/> cough dry | <input type="checkbox"/> cough up blood |
| <input type="checkbox"/> tingling | <input type="checkbox"/> frequent colds | <input type="checkbox"/> ankle swelling |
| <input type="checkbox"/> murmurs | <input type="checkbox"/> tight chest | <input type="checkbox"/> short of breath |
| <input type="checkbox"/> angina | <input type="checkbox"/> chest pains | <input type="checkbox"/> night sweats |
| <input type="checkbox"/> rapid heart | <input type="checkbox"/> skipped beats | <input type="checkbox"/> other |

Which is your main symptom? _____

When is this symptom worse:

- | | | |
|----------------------------------|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> morning | <input type="checkbox"/> afternoon | <input type="checkbox"/> evening |
| <input type="checkbox"/> spring | <input type="checkbox"/> summer | <input type="checkbox"/> fall |
| <input type="checkbox"/> winter | <input type="checkbox"/> year round | <input type="checkbox"/> before lunch |
| <input type="checkbox"/> other | | |

Which medications relieve you best?

How soon?

For how long?

_____	_____	_____
_____	_____	_____
_____	_____	_____

How far can you walk vigorously before becoming short of breath?

NUTRITIONAL HISTORY

Food	Daily	Weekly	Monthly
Alcohol type			
Soda			
Ice Cream			
Candy			
Beef			
Bacon/sausage			
Butter (pat)			
Margarine (pat)			
Cold breakfast cereal			
Chicken			
Fish			
Raw fruit			
Bran			
Soy/tofu			
Rice			
Potatoes			
Tomatoes			
Green veggies			
Eggs (1)			
Yogurt (8oz)			
Cheese (2oz)			
Pastries/cookies			
Catsup			
Honey (tblsp)			
Sugar (tsp)			
Coffee			
Tea regular			
Herbal			
Instant breakfast cereal			
Raw veggies			
Salad			
Bread			
Milk			
Yellow veggies			
Citrus			

List all the foods you have ever avoided because they bother you:

FOOD HISTORY

Do you frequently have:

- | | |
|--|---|
| <input type="checkbox"/> excessive hunger | <input type="checkbox"/> weight loss |
| <input type="checkbox"/> overindulge foods | <input type="checkbox"/> crave beverages |
| <input type="checkbox"/> eat daytime snacks | <input type="checkbox"/> bothered by food odors |
| <input type="checkbox"/> skip meals | <input type="checkbox"/> crash diets |
| <input type="checkbox"/> rotation diet | <input type="checkbox"/> use convenience food |
| <input type="checkbox"/> use exotic food | <input type="checkbox"/> weight gain |
| <input type="checkbox"/> excessive thirst | <input type="checkbox"/> eat "junk" food |
| <input type="checkbox"/> crave certain foods | <input type="checkbox"/> elimination diet |
| <input type="checkbox"/> avoid certain foods | <input type="checkbox"/> cook from "scratch" |
| <input type="checkbox"/> have bedtime snacks | <input type="checkbox"/> eat regular meals |

As an infant or child, did you ever have:

- | | |
|--|--|
| <input type="checkbox"/> bothered by food | <input type="checkbox"/> leg aches |
| <input type="checkbox"/> poor appetite | <input type="checkbox"/> fussiness |
| <input type="checkbox"/> bottle fed | <input type="checkbox"/> wet the bed |
| <input type="checkbox"/> eczema | <input type="checkbox"/> failure to thrive |
| <input type="checkbox"/> constipation | <input type="checkbox"/> constant hunger |
| <input type="checkbox"/> diarrhea | <input type="checkbox"/> skin rash |
| <input type="checkbox"/> headaches | <input type="checkbox"/> vomiting |
| <input type="checkbox"/> hyperactivity | <input type="checkbox"/> stomachaches |
| <input type="checkbox"/> behavior problem | <input type="checkbox"/> night sweats |
| <input type="checkbox"/> short attention span | <input type="checkbox"/> learning problem |
| <input type="checkbox"/> bothered by beverages | <input type="checkbox"/> dyslexia |
| <input type="checkbox"/> picky eater | <input type="checkbox"/> depressed |
| <input type="checkbox"/> colic | <input type="checkbox"/> withdrawn |
| <input type="checkbox"/> hives | <input type="checkbox"/> other |
| <input type="checkbox"/> gassiness | |

Is there a family history of allergies or food intolerance? _____

Are most of your meals: at home _____ at restaurants _____ gourmet _____

Do you mostly eat foods that are: fresh _____ canned _____ frozen _____ packaged _____

What is your favorite or most enjoyed food and beverage? _____

CHEMICAL AND INHALANT HISTORY

Please check your occupational exposures:

- | | |
|--|--|
| <input type="checkbox"/> office worker | <input type="checkbox"/> work around chemicals |
| <input type="checkbox"/> salesperson | <input type="checkbox"/> work around cosmetics |
| <input type="checkbox"/> professional worker | <input type="checkbox"/> work around dust |
| <input type="checkbox"/> factory worker | <input type="checkbox"/> work around fumes |
| <input type="checkbox"/> construction | <input type="checkbox"/> work with animals |
| <input type="checkbox"/> farm worker | <input type="checkbox"/> work indoors |
| <input type="checkbox"/> hospital worker | <input type="checkbox"/> work outdoors |
| <input type="checkbox"/> house worker | <input type="checkbox"/> work in extreme heat |
| <input type="checkbox"/> teacher | <input type="checkbox"/> work in extreme cold |
| <input type="checkbox"/> painter | <input type="checkbox"/> other |

Check if exposed to, double check if have symptoms from:

- | | | |
|--|---|--|
| <input type="checkbox"/> dust | <input type="checkbox"/> rugs | <input type="checkbox"/> perfumes |
| <input type="checkbox"/> grain dust | <input type="checkbox"/> old carpet | <input type="checkbox"/> newsprint |
| <input type="checkbox"/> chemicals | <input type="checkbox"/> new carpet | <input type="checkbox"/> art supplies |
| <input type="checkbox"/> fireplace | <input type="checkbox"/> cotton | <input type="checkbox"/> fresh newspapers |
| <input type="checkbox"/> mildew | <input type="checkbox"/> kapok | <input type="checkbox"/> old magazines |
| <input type="checkbox"/> molds | <input type="checkbox"/> sisal | <input type="checkbox"/> photocopy paper |
| <input type="checkbox"/> potted plants | <input type="checkbox"/> hemp | <input type="checkbox"/> paints |
| <input type="checkbox"/> slab home | <input type="checkbox"/> glue | <input type="checkbox"/> varnishes |
| <input type="checkbox"/> raised home | <input type="checkbox"/> tar | <input type="checkbox"/> lacquers |
| <input type="checkbox"/> new home | <input type="checkbox"/> smoke | <input type="checkbox"/> turpentine |
| <input type="checkbox"/> old home | <input type="checkbox"/> tobacco smoke | <input type="checkbox"/> furniture polish |
| <input type="checkbox"/> marshy area | <input type="checkbox"/> solvents | <input type="checkbox"/> floor wax |
| <input type="checkbox"/> wooded area | <input type="checkbox"/> cosmetics | <input type="checkbox"/> detergents |
| <input type="checkbox"/> feathers | <input type="checkbox"/> eye makeup | <input type="checkbox"/> disinfectants |
| <input type="checkbox"/> dog inside | <input type="checkbox"/> nail polish | <input type="checkbox"/> incense |
| <input type="checkbox"/> cat inside | <input type="checkbox"/> hairsprays | <input type="checkbox"/> moth balls |
| <input type="checkbox"/> bird inside | <input type="checkbox"/> soaps | <input type="checkbox"/> alcohol |
| <input type="checkbox"/> pet inside | <input type="checkbox"/> deodorants | <input type="checkbox"/> fertilizers |
| <input type="checkbox"/> insecticides | <input type="checkbox"/> dyes | <input type="checkbox"/> floor furnace |
| <input type="checkbox"/> herbicides | <input type="checkbox"/> gasoline fumes | <input type="checkbox"/> space heaters |
| <input type="checkbox"/> plastics | <input type="checkbox"/> exhaust fumes | <input type="checkbox"/> gas stove/heat |
| <input type="checkbox"/> rubber | <input type="checkbox"/> diesel fuel | <input type="checkbox"/> central heat/cool |

___ drapes

Check if you have symptoms:

___ housecleaning ___ from dyes ___ when too hot ___ spring
 ___ when too cold ___ worse at night ___ worse in daytime ___ summer
 ___ in humid/windy weather ___ around odors ___ in moldy areas ___ fall
 ___ when cutting grass ___ when raking leaves ___ when physically exerted ___ winter

List family hobbies (model planes, etc.) _____

List family work exposures (e.g. parent, spouse) _____

DRUG HISTORY

Are there any drugs you take on a regular basis? _____

List any allergenic drug or injection with symptoms:

Drug	Symptoms	Drug	Symptoms
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever reacted to:

Dental anesthetics ___ tetanus antitoxin ___ tetanus toxoid ___
 Iodides ___ X-ray contrast media ___ Penicillin ___

List any drugs which have relieved you and which cause no reaction:

Do you require: normal ___ low ___ high ___ doses of drugs as a rule?
 Does your condition require frequent use of antibiotics? _____
 Which? _____
 List your maximum weight: _____ minimum weight _____ desired weight _____
 Do you exercise regularly? _____ What type _____ How often _____
 Do you consider yourself to be under (low, moderate, high) levels of stress? _____

WOMEN ONLY

___ number of pregnancies ___ premature births
 ___ number of births ___ caesarians
 ___ miscarriages ___ abortions
 ___ menopause ___ taking hormones/ hot flashes

Breasts

___ soreness before periods
 ___ soreness not related to periods
 ___ soreness during periods
 ___ had breast biopsy
 ___ cysts or lumps
 ___ had mastectomy

Menses

___ age at onset ___ use douches
 ___ tense before ___ am now pregnant
 ___ use IUD foam ___ had D & C
 ___ use foam ___ scant flow
 ___ backaches ___ heavy flow
 ___ had miscarriage ___ have cramps

- pelvic infections
- dizzy during
- weight increase
- tense during
- partial hysterectomy
- total hysterectomy
- ovulation pain

- use lubricants
- fibroids
- pain w/intercourse
- depressed before/during
- regular/irregular periods
- use diaphragm
- dizzy before