Southside Chiropractic

Dr. Jonathan Golub
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Bellmore NY 11710
(516) 783-3700

REG

copay:___

NAME: _____ DATE: _____ AGE: _____ SEX: _____

ADDRESS: _____ DATE OF BIRTH: _____

HOME PHONE #: _____ WORK #: _____ CELL: _____

SOCIAL SECURITY #: _____ INSURANCE ID: _____

INSURANCE COMPANY: _____ GROUP #: _____

EMPLOYER: _____ OCCUPATION: _____

REFERRED BY: _____ MARITAL STATUS: _____ # CHILDREN: _____

REASON FOR YOUR VISIT: _____

_____

HOW DID IT START? _____ WHEN DID IT START? _____

WHAT MAKES IT BETTER? _____ WORSE? _____

WHEN HAVE YOU BEEN IN CAR ACCIDENTS / OTHER INJURIES? _____

WHEN WERE YOU LAST SEEN BY A CHIROPRACTOR? _____

NAME AND PHONE # OF YOUR PRIMARY PHYSICIAN: _____

WHEN HAVE YOU BEEN IN THE HOSPITAL? _____ REASON: _____

WHEN WAS THE LAST TIME YOU HAD X-RAYS TAKEN? _____

May we contact you by Email ? _____
Email address

Please list any medications & vitamins you take

Medication / Vitamin	Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

DOCTOR'S NOTES:

CC:
O:
P:
Q:
R:
S:
T:

DX:

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PLEASE CHECK ALL PROBLEMS & SYMPTOMS YOU EXPERIENCE

_____ HEADACHE
_____ STIFF NECK
_____ SLEEPING PROBLEMS
_____ BACK PAIN
_____ NERVOUSNESS
_____ TENSION
_____ IRRITABILITY
_____ CHEST PAIN
_____ SKIN CHANGES
_____ DIZZINESS
_____ PINS & NEEDLES IN ARMS
_____ PINS & NEEDLES IN LEGS
_____ NUMBNESS IN FINGERS
_____ NUMBNESS IN TOES
_____ SHORTNESS OF BREATH
_____ FATIGUE
_____ DEPRESSION
_____ LIGHT BOTHERS EYES
_____ EARS RINGING / BUZZING
_____ LOSS OF BALANCE
_____ FAINTING
_____ LOSS OF SMELL / TASTE
_____ DIARRHEA
_____ UPSET STOMACH
_____ CONSTIPATION
_____ COLDS SWEATS
_____ FEVER
_____ ANY INFECTIOUS DISEASES WE SHOULD KNOW ABOUT

DOCTOR'S NOTES

PAIN IN:

NECK L____ R____
SHOULDER L____ R____
ARM L____ R____
ELBOW L____ R____
HAND L____ R____
UPPER BACK L____ R____
MID BACK L____ R____
LOWER BACK L____ R____
HIP L____ R____
THIGH L____ R____
CALF L____ R____
KNEE L____ R____
ANKLE L____ R____
CHEST AREA L____ R____
ABOVE STOMACH ____
BELOW STOMACH ____
GALL BLADDER AREA ____
APPENDIX AREA ____
KIDNEY AREA ____
PAINFUL MENSES ____
PROSTATE PROBLEMS ____
OTHER: _____

ANYTHING ELSE THE DOCTOR SHOULD KNOW?

_____

_____

_____

DOCTOR'S NOTES

If **FEMALE,** is there any chance you are **PREGNANT**?
_____ **YES** _____ **NO**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Jonathan Golub will prepare reasonable and necessary paperwork to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Dr. Golub (Southside Chiropractic) will be credited to my account upon 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 care and treatment, any fees for professional services rendered me will immediately be due and payable.

Patient's Signature: **X**_____

Today's Date: _____

Parent/Guardian/Spouse
Signature authorizing care: _____

MARK AREAS OF PAIN