Today's Date (month/day/year): ______/______/________
Z#: __________

PATIENT RE-EVALUATION FORM

CONTACT INFORMATION:

First Name: _________________________ Middle Name: __________________ Last Name: ______________________________

Address: ____

City: __________________________________ State: __________ Zip: ____________________

Home Phone #: (____)______-_______ Cell #: (____)______-_______ Work Phone #: (____)______-_______

Contact Preference:_________________ Do you want text reminders for your appointments?_________________

Email Address: ___________________________________

Emergency Contact: ______________________________ Relationship: ____________________ Ph: (______)______-________

Do we have permission to discuss scheduling/appointments with emergency contact? Yes or No

Do we have permission to discuss financial amount owed or credit with emergency contact? Yes or No

PRIMARY CARE PHYSICIAN:

First Name: ______________________________ Last Name: ______________________________ Group: __________________

Doctor's Address: __________________________City: ______________________ State: __________ Zip: ________________

INSURANCE INFORMATION: *(If your insurance has changed since your last visit please present your benefit card to the front desk staff with this completed form)*

Jarosz Chiropractic, P.C. Wellness Locations:
143 N. Washington St Ste 1. Rome, NY 13440 (315)339-2422
151 Genesee St. New Hartford, NY 13413 (315)339-2422

PATIENT HISTORY & CONSULTATION:

Describe the health concern you are experiencing: ____

____

____

How long have you been suffering with this? ____

What do you think caused your health complaint? ____

____

Is this health concern related to a worker's compensation injury or a No Fault injury (car accident): Yes or No

If yes, what was the injury and when? ____

Have you ever experienced this before? ____

What makes your problem worse? ____

Does anything improve your problem? ____

Have you had any diagnostic tests performed for this complaint? (circle one) X-rays CT Scan MRI Nerve Testing (EMG) Other

PATIENT DIAGRAM: *(Please circle the area(s) that are bothersome and show any radiation of pain/symptoms with an arrow)*

Front

R L

Back

L R

Rate the severity of your condition by circling a number below [Zero equals none/Ten is severe].

Neck Region:

(________________________________)
0 1 2 3 4 5 6 7 8 9 10
no pain severe pain

Mid-Back Region:

(________________________________)
0 1 2 3 4 5 6 7 8 9 10
no pain severe pain

Lower Back and Leg Region:

(________________________________)
0 1 2 3 4 5 6 7 8 9 10
no pain severe pain

I have been provided a copy of the terms of acceptance, consent to use and disclosure of protected Health Information, as well as appointment policies for this office.

Patient Signature:_______________________________ Today's date:____________________

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