

Southside Chiropractic

Dr. Jonathan Golub

(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

DOCTOR'S NOTES

- ☐ 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

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: _____

DOCTOR'S NOTES

ANYTHING ELSE THE DOCTOR SHOULD KNOW?

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.

Parent/Guardian/Spouse

Patient's Signature: **X** _____

Today's Date: _____

Signature authorizing care: _____

MARK AREAS OF PAIN

