Dr. Juliana Marciniak, D.C.
Dr. Jennifer Gilmore D.C.
2625 Delaware Ave. Buffalo, NY 14216
P: 716-335-9711 F: 716-335-9696
E: PeakPerformanceChiropracticWNY@gmail.com

Registration Form

This information is needed so we can better serve you. Please fill in ALL portions of the form. If you need assistance, please ask our receptionist, and we will be happy to have our Patient Services Representative help you.

Today's Date: ___/___/___
Name: ____ **Gender:** M F
Marital Status: M S D W
Address: ____
City: ______________________________ **State:** _________ **Zip:** _________________
Home Phone: __________________________ **Work Phone**:_________________________
Cell Phone:_____________________________
Preferred phone: Home Cell Work **SSN:** _________-________-___________
Date of Birth: _______/________/________ **Age:** ______
E-mail Address: ______________________________________

Occupation: ________________________ **Current Employer:** _______________________
Employer Address: ___________________________**City:** _____________
State: _____ **Zip:** _____

Whom may we contact in case of emergency?
Name: ____
Phone: _________________________ **Relationship to Patient**: _______________________

Primary Care Physician: ___________________________ **Phone:** ____________________
Office Address: ____________________________
Date of last visit to Primary Care Physician: ____________________________
Are you currently being treated for any condition(s)? If so, what condition?:
____
If yes, by whom?: ______________________________________
Are you taking any medications? Y N If yes, please list them:____________________
____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

General History

__Trauma/injured
__Height change
__Weight change
__Fever/chills
__Sweats
__Allergies
__Anemia
__Bleeding/bruising
__Malaise/fatigue
__Weakness
__Cancer

Family History

__Diabetes
__Thyroid Disease
__Tuberculosis
__Kidney Disease
__High blood pressure
__Heart disease/stroke
__Muscle/joint disease
__Cancer
__Other

Endocrine System

__Heat/cold intolerance
__Thyroid problems
__Diabetes
__Neck surgery
__Neck irradiation
__Other

Eye/Ear/Nose/Throat

__Visual problems
__Pain in the eyes
__Difficulty hearing/deaf
__Ringing in ears/dizziness
__Ear growth/discharge/pain
__Nose bleeds
__Change in ability to smell
__Nose growths/discharge/pain
__Sinusitis

Cardiovascular System

__Shortness of breath
__Time of day
__How often
__Chest discomfort/pain
__Calf pain walking
__How often
__High blood pressure

Gastrointestinal System

__Change in appetite
__Food intolerance
__Nausea/vomiting
__Vomiting of blood
__Peptic ulcer
__Indigestion/heartburn
__Abdominal pain
__Abdominal swelling
__Change in stool/color/etc.

Gastrointestinal System

__Diarrhea
__Hernia
__Hemorrhoids
__Gallbladder disease
__Pancreatitis

Urinary System

__Frequent urination
__Pain on urination
__Change in urine /color
__Difficulty in holding urine
__Discharge

Urinary System

__Flank pain
__Urinary tract infections
__Kidney disease
__Pelvic pain
__Other problems

Respiratory System

___Difficulty in breathing
___Cough
___Blood in sputum
___Wheezing/Asthma
___Tuberculosis/ exposure
___Pneumonia/Lung infection

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___Cigarette smoking/tobacco use

Please list any other health problems you have, no matter how insignificant they may be:____
____
____
____

Whom may we thank for referring you to us?
____

<u>Current Problem</u>
Chief Complaint/Purpose of this appointment:
____
Location of Complaint:____
Complaint Began when and how:
____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _______
Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?____
Do you have any numbness or tingling in your body? Where?
____
Grade Intensity/Severity
(No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)
How frequent is complaint present, how long does it last?
____
Does anything aggravate the complaint?
____
Does anything make the complaint better?
____
Other doctors consulted for this condition:
____
Is this condition accident related? Y N
If yes; Type of accident: Vehicular Work related Slip/Fall

Date of accident: _____________ **Attorney Name (if applicable):** _________________

Imaging Studies: (circle all that apply) X-ray, CT scan, MRI, bone scan, other:___
_____

Body area imaged: _______________ **Facility:** _______________ **Date:**____________

Insurance Information: (Please present your insurance card to the reception desk)

Please note that if the insurance policy holder is not you, we need the policy holders name, date of birth, address, and your relationship to that person. Thank you.

Name/Address of Insurance Company:
____

Policy Holders Name: _______________________**Policy Holders DOB:** ______________

Policy Holders Address: ____

Relationship to Patient: Self Spouse Parent Other

Person Responsible for Payment: _______________________________________

Informed Consent for Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and rehabilitation, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire

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course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I attest that the above information is true and correct to the best of my knowledge. If applicable, I authorize my insurance benefits to be paid directly to Peak Performance Chiropractic. I further understand and agree that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or settlement.

I also understand that if I am responsible for a co-payment by my insurance company, it is due on the day of the visit.

Dr. Juliana Marie Marciniak or Dr. Jennifer Gilmore if need be, may use my health care information and may disclose such information to my insurance company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Patient's Signature:___________________________________ Date:______________
Parent/Guardian's Signature, if minor: _________________________
Relationship, if minor: _________________________

Witnessed By: ____________________________________ Date:______________