



Dr. Juliana Marciniak, D.C.  
Dr. Jennifer Gilmore D.C.  
2625 Delaware Ave. Buffalo, NY 14216  
P: 716-335-9711 F: 716-335-9696  
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## 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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**How did you hear about Peak Performance Chiropractic?**

Google      Facebook      Instagram      Yelp

Referral from \_\_\_\_\_

**Current Problem**

**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.



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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

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:** \_\_\_\_\_