



DR. NICHOLAI SOROCHINSKY

FULLEST LIFE CHIROPRACTIC

100 LINDEN OAKS DR. SUITE 203

PENFIELD, NY 14625

(585) 672-5301

WWW . FULLESTLIFE . COM

“Helping You Live Your Life to the Fullest!”

Welcome to our office!

Please fill this out as **thoroughly** as possible to save time during the initial visit. Thank You!

Patient Information

Name (Last, First, MI)						
Address						
City		State	Zip			
Phone Primary: home, cell, work		Phone 2nd: home, cell, work				
Email		How did you hear about us?				
Birth date:	Sex:					
Marital Status	Single	Married	Widowed	Divorced	Separated	Other :
Spouse's Name			Number of Children			
In case of emergency notify/ relation			Phone			
May we contact you via email with updates and newsletters? yes no						

Employment Information

Employer		Occupation		
Address		City	State	Zip
Phone:		Fax:		

Insurance & Attorney Information

Is your condition due to an auto accident or work related injury (chose one)? yes no			Injury Date
Has your case been or will your case be referred to an attorney or workers compensation for any reason? yes no			
Attorney's Name		Phone	
Address			
Health Insurance Carrier(s) Primary:		Secondary:	
Contract Number		Relation to Insured self spouse child	
Referral #			

Primary Care Physician

Name of medical doctor / physician			
Address			Telephone
Date Last Seen	May we contact him/her about your health?		yes no
Did your physician have any concerns at that time?			

Health History

Please identify the health concern(s) that have brought you to Dr. Sorochinsky's office.

Reason for visit	Past Treatment (including over the counter meds/ice/heat)	Did this help you?
1.		yes no explain:
2.		yes no explain:
3.		yes no explain:

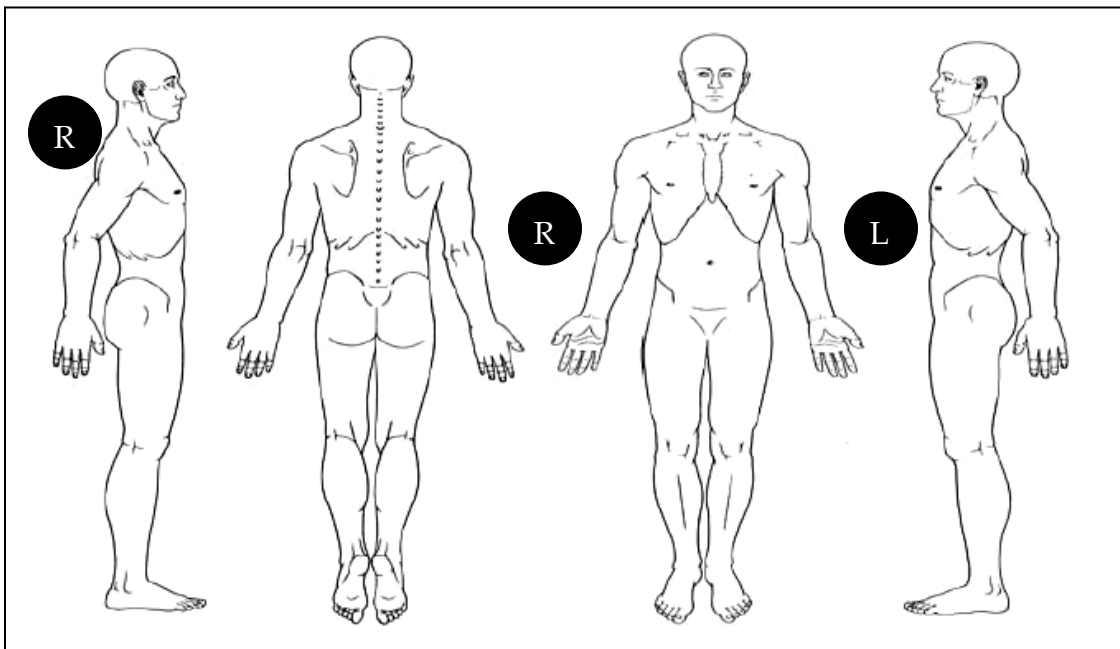
Have you ever been to a chiropractor before? If yes, who?

yes no

Have you seen anyone else for your current concerns? If yes, who?

yes no

Please identify the areas below where you are having your symptoms currently.



Rate the severity of your symptoms from 0 to 10, 10 being the most severe.

0 1 2 3 4 5 6 7 8 9 10

X _____
Signature

Date _____

Describe the type of pain (check all that apply) **Sharp** **Dull** **Throbbing** **Numbness** **Ache** **Shooting** **Tingling**
Cramps **Stiffness** **Swelling** **Other:** _____

When did your symptoms appear for the very first time?

Best date:

When was the most recent occurrence of your symptoms?

Best date:

Is this injury related to a car crash or your work in any way?

yes no

Progression: My condition is **getting worse** **staying the same** **getting better** **comes & goes** explain:

Briefly explain how this started.

Health History Continued

How often do you have this symptom or pain?

Is it constant or does it come and go?

General Information

List **all** drugs, vitamins & supplements [prescribed, recreational, or over-the-counter] in the following format:

ex. Drug Name (reason for taking the drug)

Are you on medication right now? yes no

List **all** allergies of any type.

Does coughing, sneezing or bowel movements reproduce your pain? yes no
Average # of bowel movements per day _____ Any recent changes?

Have you noticed any loss of bowel, bladder control, sexual function? _____
yes no

Have you had any unexplained weight change? yes no

Have you had any unexplained fever, chills, or night sweats? yes no

Have you had an increase of pain at night? yes no

Are you having a *new* headache like you've never had before? yes no

Is there *any chance* that you might currently be pregnant? yes no

If you know yourself to be pregnant, how far along are you? _____ months

Do you have any infectious diseases? yes no

If yes, please indicate

which: _____

Medical and Surgical History

1. Height: _____ Current Weight: _____

2. Blood Pressure: When was your last reading? _____ What was the last reading? _____

3. Please list any major accidents, falls, or other related trauma (including sports) **and their dates**.

4. Please list any major diseases **and their dates**.

5. Please list surgeries of any type (including dental work) or hospitalizations **and their dates**.

6. Please list any X-rays, CAT scans, MRI's, blood tests or any other special studies **with their reasons and dates**.

7. Childhood illnesses (please circle all that you had)

Rheumatic Fever Mumps Measles Chicken Pox

8. Immunizations (please circle all that you had)

Polio Tetanus Measles/Mumps/Rubella Pertussis Diphtheria Influenza H1N1 Others: _____

9. Emotional (please circle all that you have **currently**. Put a "P" to indicate if you had this in the **past**)

Mood Swings Nervousness Mental Tension Anxiety Attacks Depression Under Emotional Stress
Psychiatric Disorder Suicide Attempt Are you under psychiatric care currently? yes no

10. Energy & Immunity (please circle all that you have **currently**. Put a "P" to indicate if you had this in the **past**)

Fatigue Slow Wound Healing Chronic Infections Recurring Illness Chronic Fatigue Syndrome Get colds often

11. Head, Eye, Ear, Nose, & Throat (please circle all that you have **currently**. Put a P to indicate if you had this in the **past**)

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness Impaired Hearing
Ringing in Ears Earaches Headaches Sinus Problems Nose Bleeds Frequent Sore Throats
Teeth Grinding TMJ/ Jaw problems Hay Fever

12. Respiratory (please circle all that you have **currently**. Put a "P" to indicate if you had this in the **past**)

Pneumonia Frequent Common Colds Difficulty Breathing Shortness of Breath Emphysema Persistent Cough
Pleurisy Asthma Tuberculosis (TB) Other Respiratory Problems: _____

13. Cardiovascular (please circle all that you have **currently**. Put a "P" to indicate if you had this in the **past**)

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure Palpitations/ Heart Flutters Stroke Pacemaker
Heart Murmurs Rheumatic Fever Varicose Veins Easy Bleeding/ Bruising On Blood Thinners Bleeding Disorder

14. Gastrointestinal (please circle all that you have **currently**. Put a "P" to indicate if you had this in the **past**)

Ulcers Changes in Appetite Nausea/Vomiting Abdominal Pain Gas Heartburn Acid Reflux
Gall Bladder Disease Liver Disease Hepatitis Dark Stool Bloody Stool Diarrhea Hemorrhoids
Appendicitis Irritable Bowel Syndrome Take Ant-acids

15. Genito-Urinary Tract (please circle all that you have **currently**. Put a "P" to indicate if you had this in the **past**)

Kidney Disease Painful Urination Frequent UTI Frequent Urination Kidney Stones
Impaired Urination Blood in Urine Frequent Urination at Night Sexually Transmitted Disease

16. Female Reproductive (please circle all that you have **currently**. Put a "P" to indicate if you had this in the **past**)

Irregular cycles Breast Lumps/ Tenderness Premenstrual Problems Heavy Flow Vaginal Discharge
Clotting Bleeding Between Cycle Menopausal Symptoms Difficulty Conceiving Painful Periods
Endometriosis Cysts on Ovaries or Uterus Headaches During Period Nipple Discharge

17. Menstrual/ Birthing History

Age of 1 st Menses:	# of Days of Menses:	Length of Cycle:	Birth Control Type:	# of Pregnancies
# of Miscarriages:	# of Abortions:	# of Live Births:	Are you currently pregnant? yes no	Due Date: _____

18. Male Reproductive (please circle all that you have **currently**. Put a "P" to indicate if you had this in the **past**)

Sexual Difficulties Prostate Problems Testicular Pain or Swelling Penile Discharge Hydrocele Vasectomy

19. Musculoskeletal (please circle all that you have **currently**. Put a "P" to indicate if you had this in the **past**)

Neck/ Shldr Pain Muscle Spasm/ Cramps Arm Pain Upper Back Pain Midback Pain Low Back Pain Leg Pain
Osteoporosis Multiple Sclerosis Prosthesis Arthritis (what type) _____
Joint Pain (if so where?): _____

20. Neurological (please circle all that you have **currently**. Put a "P" to indicate if you had this in the **past**)

Stroke Concussion Vertigo/Dizziness Paralysis Numbness/ Tingling Loss of Balance New Type of Headache
Seizures/ Epilepsy Muscle Twitching Muscle Weakness Muscle Cramping Shooting or Electric Pain
Parkinsons Pinched Nerve

21. Endocrine (please circle all that you have **currently**. Put a "P" to indicate if you had this in the **past**)

Hyper/Hypo Thyroid Hyper/Hypoglycemia Blood Sugar Problems Night Sweats Always Hot or Cold Diabetes
Goiter Cold Hands or Feet Taking Hormone replacement (natural or prescription) which: _____

22. Other (please circle all that you have **currently**. Put a "P" to indicate if you had this in the **past**)

Anemia Cancer Rashes Blood Problems Skin Problems Gout Polio Eating Disorder
Rheumatoid Arthritis Chemical Dependency Is there anything else that we should know? _____

Family History (check all those that apply)

	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)						
Health (G=good, P= poor)						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
High Cholesterol						
Stroke						
Mental Illness						
Allergies or Asthma						
Kidney Disease						
Age (at death)						
Cause of Death						

NOTICE OF PATIENT PRIVACY RIGHTS

By signing below, I acknowledge that I have received a copy of the “Notice of Patient Privacy Rights” and a copy will be available for me at the reception desk upon my request. The Health Insurance Portability and Accountability Act (HIPPA) ensures a patient’s right to privacy regarding personal health information and it is this office’s policy to maintain confidentiality to the highest degree.

Please make my health information, including appointments, balances, findings, etc available to the following people:

Patient/Legal Guardian Signature

Date:

Doctor’s Signature:

Date:

INFORMED CONSENT

While Chiropractic examination and therapeutic procedures are usually considered to be remarkably safe and effective, please understand that occasionally there may be adverse reactions. Although the chances of experiencing any of these complications are extremely small, it is the practice of this office to fully inform and educate all of our patients.

By signing below, I understand that these complications include, but are not limited to, post-adjustment soreness, muscle strain and sprain, fractures, dislocations, disc injuries, and strokes. I do not expect the doctor to be able to anticipate or explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of my treatments which they feel at the time, based upon the facts then known, is in my best interests.

I understand that there is not guarantee or warranty for a specific cure or result. I understand that at any time, I can request further explanation regarding risks and benefits of care in this office, alternative courses of care, and the consequences of not having the proposed treatment. Further, I agree to notify the doctor immediately with any concerns, if I were ever to become uncomfortable for any reason— for example if treatment is too much to tolerate, personal issues with space or touch, religious, etc. I further understand that as a chiropractor in the state on New York, Dr. Sorochinsky will address the neuromuskuloskeletal system only (things that relate to nerves, muscles, and bones).

Patient/Legal Guardian Signature

Date:

Doctor’s Signature:

Date:

OFFICE POLICIES

I agree to take full financial responsibility for my care in the event that the assumed coverage (Worker’s Compensation, No Fault Insurance, HMO, etc) is denied for any reason. I further understand that the office charges a **\$30 fee for returned checks**. I also understand that this office operates on a **fee-for-service basis**. If payment is not made at the time services are rendered, I understand that the office reserves the right to charge a \$10 fee. Overdue payment charges of \$20 accrue every 30 days.

The office reserves the right to charge for appointments canceled without 24 hours notice and for not attending scheduled appointments. After that allowance is made, the office will charge up to 100% of the *cash value* of the scheduled appointment, *not just a copay*. Patients *late* for appointments have the option of either using the remainder of the time scheduled at the full price as scheduled, or the patient may reschedule the appointment and be charged for the missed visit.

Patient/Legal Guardian Signature

Date:

Doctor’s Signature:

Date: