Barry Heffron, D.C. P.C.
165 N. Village Ave., Suite 128, Rockville Centre, NY 11570
Tel: 516-764-2222 Fax: 516-764-7314

Please Tell Us About You

Print your name: ______________________________________ Date of birth______________ Age: ______

Address: __________________________ City ___________________ State _________ Zip _____________

Phone # Home ______________________Cell # ______________________Work #______________________

SS# _______ -_______ - _______ Email Address ____

Single ☐ Married ☐ Spouse's name ____

Who referred you to our office? ____

Employer Information

Employed by: ____

Employer's Address: ____

Your occupation: ____

Insurance Information

Insurance Company Name:____

Address ____ Phone # ______________________________

Insured's Name: ____________________________________ Date of Birth _______________Age _______

Insured's SS # ______ _______ _______ Relationship to you:_______________________________________

Group #:____

Insured's Employer's Name: ______________________________________

Financial and Insurance Policy

Chiropractic coverage is offered by most insurance companies, some insurance companies do not cover care. If you have coverage, and your initial deductible has been met, we will accept assignment of insurance benefits which will reduce your out of pocket expense. If you have limited or no insurance coverage, we will discuss our various payment programs.

Will you be paying by: Cash ☐ Check ☐ Charge Card ☐

Health History

What are your Main Complaints? ____

____

Have you had this problem longer than a week? Yes □ No □ How long? ________________________

Have you had this problem more than 2 or 3 times? Yes □ No □ When?_________________________

Before you began to suffer with this problem, was there an earlier accident, incident or condition that could have brought this about or can be related to? (Example: Fall, Auto Accident, Sports Injury, Workers' Compensation)

____

Do these problems interfere with life at: Home □ Social □ Work □

What physical activities do you participate in?____

What have you tried to get rid of these problems? ____

Who have you seen for this problem?

Medical Doctor □ Osteopath □ Physical Therapist □ Massage Therapist □

Did you achieve the results you wished? Yes □ No □

List any and all medications and vitamins you currently take. Include over-the-counter drugs!

____

____

Have you had any surgery in the past? Yes □ No □ List any surgical procedures____________________

____

Are you under Stress? Yes □ No □

Have you ever suffered from or have been diagnosed in the past or present with:

Dizziness □ Headaches □ Shortness of breath □ Asthma □ Allergies □

Heart Problems/Chest pain □ Blood Pressure □ Digestive Problems □ Sinus Problems □

Diabetes □ Cancer □ Back Problems □ Other ______________________________________

Do you know what type of delivery technique was used when you were born?

C-Section □ Vaginal □ Forceps □

Health History

What have you heard about Chiropractic?

Have you ever been to a chiropractor before? Yes □ No □

Did he/she explain the affects of Vertebral Subluxations to you? Yes □ No □

Have you become worried about getting the problem handled? □ I've been discouraged □ I'm learning to live with it, but really want to fix it!

What makes this problem worse? □ Standing □ Sitting □ Laying down □ Bending □ Lifting

Have you had to reduce your level of activity? Yes □ No □
If yes: How? ____

How does this affect/interfere your work and your social life?
□ is it aggravated there □ others concerned □ potential to jeopardize job □ Less sports

When it is at its worst, how much older does this problem makes you feel?

Concerning your specific problem(s), does anyone else in your family have similar complaint(s)? □Yes □ No
If yes, who? ____________________________

List below names and ages of your children: ____________________ ____________________
____________________ ____________________ ____________________

On a scale of 1-10. Ten being the highest, rate your level of commitment to get rid of this problem.
If not a 10 determine why? Is it □ Time □ Money □ Fear
If this wasn't an issue, would it then be a ten?

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature ____ Date __________________