Dr. Jason Piken
Office Address: 119 West 57th Street, Suite 712 New York, NY 10019 Office phone: 212 581 9079
Email: drp@drjasonpiken.com

Patient Information

Thank you for choosing Innate Chiropractic of Manhattan for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We are happy to help.

Name: First Middle Initial Last SS/HIC/Patient ID #:

Address: City State Zip Code

Sex: Birthdate: Email:

Home Phone: Cell Phone: Work Phone:

Do you prefer to receive calls at: ☐ Home ☐ Work ☐ Cell ☐ No Preference

◯ Married ◯ Widowed ◯ Single ◯ Minor ◯ Separated ◯ Divorced ◯ Partnered for ___ years

Patient Employer/School: Occupation:

Employer/School Address: City: State: Zip Code:

Spouse or parent's name: Employer: Work Phone:

Whom may we thank for referring you to us?

Person to contact in case of emergency: Phone:

Responsible Party

Name of person responsible for this account:

Relationship to patient: Phone:

Address: City: State: Zip Code:

Name of employer: Work Phone:

Symptoms

Reason for visit: When did you first notice the symptoms?

Is the condition getting progressively worse? Where specifically is the problem(s) located?

Which activities are difficult to perform? ☐ Sitting ☐ Walking ☐ Bending ☐ Lying Down ☐ Other

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

Rate the severity of your pain. (1 = mild pain or discomfort, to 10 = severe pain)

Is the pain constant or does it come and go?

What treatment have received for your condition?

☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Other

Name and address of other doctor(s) who have treated you for your condition:

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Health History (Check only those conditions which are applicable)

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergy Shots
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disc
- ☐ Herpes
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostrate Problems
- ☐ Prosthesis
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors, Growths
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease
- ☐ Whooping Cough
- ☐ Other

Dates of last exam:

(Woman) Are you pregnant? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No Taking Birth Control Pills? ◯ Yes ◯ No

List any types of surgeries which you have had and the dates which they occurred:

Please list all medications you are currently taking:

Allergies:

Daily Habits

What type of exercise do you perform on daily basis? ◯ None ◯ Moderate ◯ Heavy

What do your daily works habits include?

What vitamins do you currently take? Nutritional supplements (if any)?

Do you smoke? ◯ Yes ◯ No How much per day?

How much liquor do you consume weekly?

How many caffeinated beverages do you consume daily?

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Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child ever have a change in health.

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Piken may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date sign below.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Date

Clear All

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