Welcome to
DR. CHRISTINA KULESZ
BATAVIA CHIROPRACTOR

Patient Information

Name: ______________________________
First MI Last

Date of Birth: ____________ Age: ________

SS#: ________________ Sex: M F

Address: ______________________________

____

City: __________ State:_______ Zip Code:_______

Occupation: ______________________________

Employer: ______________________________

Employer Address: ______________________________

____

☐Single ☐Married ☐Widowed ☐Separated ☐Divorced ☐Other

Spouse's Name: ______________________________

Today's Date: ____________________
Whom may we thank for referring you? (Or how did you hear about our office?) ____________________
Reason for visit: 1): ____________________

2): ____________________

Insurance

Person responsible for account: ____________________

DOB: ______ Relationship to patient:______________

Insurance Co. ______________________________

Policy #: ______________ Group #: __________

If you have chiropractic benefits, would you like us to bill your insurance? ☐Yes ☐No

ASSIGNMENT AND RELEASE
I, the undersigned, certify that I (or my dependent) have insurance coverage with________________ and assign directly to Dr. Christina C. Kulesz all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

______________________________ ______________
Responsible Party Signature Date

Phone Numbers

Home Phone: ______________________________

Work Phone: ______________________________
Is it okay to call you at work? ☐Yes ☐No

Cell Phone/Other: ______________________________

e-mail: ______________________________

IN CASE OF EMERGENCY CONTACT:

Name: ______________ Phone: ______________

Relationship to patient: ______________________

Accident Information

Is condition due to an accident? ☐Yes ☐No

Type of accident? ☐Auto ☐Work ☐Home ☐Other

Date of accident: _________ Accident State: ________

To whom have you made a report of your accident?
☐Auto Insurance ☐Employer ☐Worker Comp. ☐Other

Attorney Name (if applicable): ____________________

EXERCISE	WORK ACTIVITY	HABITS	
☐None	☐Sitting	☐Smoking	Packs/Day ______________
☐Moderate	☐Standing	☐Alcohol	Drinks/Week ______________
☐Daily	☐Light Labor	☐Coffee/Caffeine Drinks	Cups/Day ______________
☐Heavy	☐Heavy Labor	☐High Stress Level	Reason ______________

Women: Are you pregnant? ☐Yes ☐No ☐Unsure Date of Last Menstrual Period:______________

Continue on Reverse ➔

DR. CHRISTINA KULESZ
BATAVIA CHIROPRACTOR

Patient's Name: ____ Today's Date: ______________

Patient Condition

What is your present complaint(s)? Onset Date:

______________________________ ____________

______________________________ ____________

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

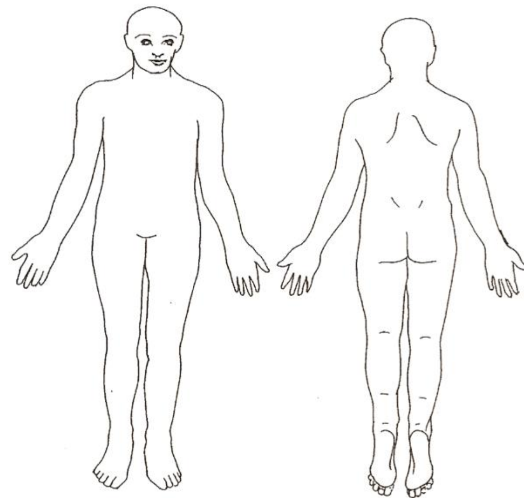
The problem is (please circle):
getting worse getting better staying the same
How often do you have this pain? ____________________________
The pain is (please circle): Constant or Comes and goes

Does it interfere with your:
☐Work ☐Sleep ☐Daily Routine ☐Recreation

Activities or movements that are painful to perform:
☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying down

List any treatments or medications you have received for this condition & date/how long: __________________________________

Mark an X on the picture where you continue to have pain or other symptoms.



Rate the severity of your pain on a scale from (least pain) to 10 (severe pain).
1 2 3 4 5 6 7 8 9 10

Health History

Have you received chiropractic care before? _________ If yes, from whom? ______________________________
When? ____________ How would you rate your previous care? (please circle) Satisfactory Unsatisfactory
Have you had spinal x-rays performed within the last year? _____________ If yes, when? ________________
Circle any problems you have now or have had in the past:

AIDS/HIV			Pinched Nerve
Allergies	Diabetes	Jaw Pain	Pneumonia
Anemia	Diarrhea	Kidney Problems	Polio
Anorexia	Dizziness	Liver Disease	Prostate Problem
Aneurysm	Emphysema	Lung Disease	Prosthesis
Arthritis	Epilepsy	Measles	Psychiatric Care
Appendicitis	Fainting	Menstrual Problems	Ringing in the Ears
Asthma	Fatigue	Miscarriage	Scoliosis
Bleeding Disorders	Fracture	Mononucleosis	Sinus Problems
Breast Lump	Glaucoma	Multiple Sclerosis	Spinal Fractures
Bronchitis	Gout	Mumps	Stomach Problems
Bulimia	Headaches	Muscle Weakness	Stroke
Cancer	Heart Burn	Night Sweats	Thyroid Problems
Cataracts	Heart Disease	Numbness	Tonsillitis
Chemical Dependency	Hernia	Osteoporosis	Tuberculosis
Chest Pain	High Cholesterol	Parkinson's Disease	Unexplained Weight Loss
Other _____________	Other _____________	Other _____________	Other _____________

Briefly describe any injuries, falls or surgeries you have had:

DESCRIPTION: DATE:

____ _____________

____ _____________

____ _____________

Other Problems/Concerns: ____

____