Welcome

Bedford Center Chiropractic
Anna Petrella, D.C.

Thank you for choosing our practice for your chiropractic needs. Please complete this form. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help. Please be advised that all information on this form is confidential and no information will be released without your consent.

Patient Information

Name ____ Date_________________ Gender □ M □ F

Address _______________________________________ City, State, Zip ___________________________

Home Phone _________________Cell Phone __________________Work Phone ____________________

Best place to reach you? □ Home Phone □ Cell Phone □ Work Phone

□ Email ____□ Texting_________________

Patient Employer/School __________________________________ Occupation______________________

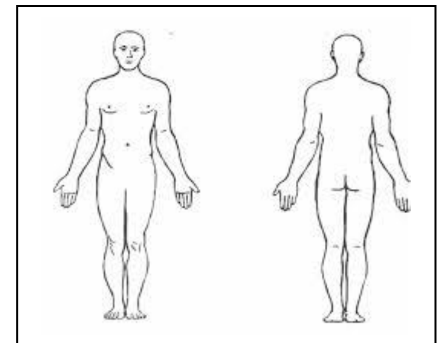
Birth Date _________ Age____ □ Single □ Married □ Widowed □ Divorced □ Partnered □Minor

Spouse/Significant Other/ or Parent's name _______________________ Number of Children_________

Whom may we thank for referring you to us? ____

Person to contact in case of emergency____________________________ Phone ____________________

Patient Condition



Mark an "X" on the picture

Reason for Visit ____

When did you first notice the symptoms? ___________________

Is this condition getting progressively worse? □ Yes □ No □ Unsure

Is this condition due to an accident? □ Yes □ No

Type of Accident □ Auto □ Work □ Home □ Other Date ___________

*****If auto or work accident, please visit front desk for additional forms.***

Where specifically is the problem(s) located? _________________________

Mark an X on the picture where you continue to have pain, numbness, or tingling.

My current pain/problem can be described as (check all that apply):

□ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting □ Burning

□ Tingling □ Cramping □ Stiffness □ Swelling □ Spasms □ Other

Rate the severity of your pain. 1 (least pain) to 10 (severe pain) _______

Is the pain constant or does it come and go? _______________________

Does it interfere with your □ Work □ Sleep □ Daily Routine □ Recreation

Activities or movements which are painful to perform: □ Sitting □ Standing □ Walking

□ Bending □ Lying Down Is the pain worse: □ AM □ PM

What treatment have you already received for your condition? □ Medication □ Surgery

□ Physical Therapy □ Chiropractic Services □ None □ Other _________________________

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

____

Health History (Please circle all that apply)

AIDS/HIV	Chicken Pox	Kidney Disease	Stroke
Alcoholism	Depression	Liver Disease	Suicide Attempt
Allergy Shots	Diabetes	Measles	Thyroid Problems
Anemia	Emphysema	Miscarriage	Tumors, Growths
Anorexia	Epilepsy	Mononucleosis	Ulcers
Appendicitis	Fractures	Multiple Sclerosis	Vaginal Infections
Arthritis	Glaucoma	Osteoporosis	Venereal Disease
Asthma	Gout	Parkinson's Disease	Vertigo
Bells Palsy	Headaches/Migraines	Pneumonia	Whooping Cough
Bronchitis	Heart Disease	Prostate Problems	Other ___________
Bulimia	Hepatitis	Prosthesis	
Cancer	Hernia	Psychiatric Care	
Cataracts	Herniated Disc	Rheumatoid Arthritis	
Chemical Dependency	High Cholesterol	Shingles	

Dates of last exams____

(Women) Are you pregnant? □ Yes □ No **Nursing?** □ 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 a daily basis? □ None □ Moderate □ Heavy

Daily work habits include: □ Sitting □ Standing □ Light Labor □ Heavy Labor □ Computer Work

What vitamins and/or nutritional supplements do you currently take?

____

Do you smoke? □ No □ Yes **How much alcohol do you consume on a weekly basis?** _______________

How much coffee or caffeinated beverages do you consume on a daily basis? _______________________

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 certify that I, and/or my dependent(s), have insurance coverage with _____________________________

and assign directly to Dr. Anna Petrella 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 authorize the use of my signature on all insurance submissions.

The above-named doctor 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 benefits or the benefits payable for related services.

____ _______________________________

Signature of Patient, Parent, Guardian or Personal Representative **Date**

____ _______________________________

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