PEAK PERFORMANCE **CHIROPRACTIC**

Helping You Live Life Without Limits

9365 McKnight Rd., Suite 500
Pittsburgh, PA 15237
(412) 366-3363

Date:_____ Name:_____

Address:_____ City:_____ Zip:_____

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

E-mail:_____ SS#:_____-_____-_____

Occupation:_____ Employer:_____

Birthday:_____/_____/_____ Age:_____ Spouse:_____ Ages of Children:_____

Referred by:_____

In case of emergency, relative/friend not living in your home: Name:_____ Phone: (_____)_____

What is your major complaint? Please by specific. _____

_____

Is your pain the result of an automobile accident or work injury? Yes □ No □ If yes, explain. _____

_____

Have you ever had surgery or been hospitalized? Yes □ No □ If yes, explain. _____

_____

Have you ever had Chiropractic Care before? Yes □ No □ If yes, name of doctor: _____ Date: _____

Last time you had spinal x-rays or other x-rays: _____

Medications you now take: _____

What type of vitamins or other nutritional supplements do you take:_____

How much/what type of exercise do you do regularly? _____

How long and well do you usually sleep? _____

Please describe car accidents/falls/injuries with approximate dates: _____

_____

Would you like to know more about the vitamins you take? _____

Are you interested in Anti-aging and Weight loss procedures? Yes □ No □ If yes, explain. _____

_____

Name of medical doctor: _____ Phone: (_____)_____

Location: _____

Last visit: _____ May we send information regarding care at our office? Yes □ No □

Please check the appropriate box for any of the following symptoms: O=Occasional F=Frequent C=Constant

O	F	C		O	F	C		O	F	C	
□	□	□	Arthritis	□	□	□	Fatigue/Tiredness	□	□	□	Sinus Problems
□	□	□	Asthma	□	□	□	Headache	□	□	□	Sore Muscles
□	□	□	Blood Pressure High/Low	□	□	□	Heart Disease	□	□	□	Vision Problems
□	□	□	Cancer	□	□	□	Loss of Sleep	□	□	□	Walking Problems
□	□	□	Chest Pain	□	□	□	Loss of Weight				
□	□	□	Colitis	□	□	□	Low Back Pain	*Pain or Numbness in:*			
□	□	□	Constipation	□	□	□	Menstrual Cramps	□	□	□	Shoulders
□	□	□	Diabetes	□	□	□	Muscle Cramps	□	□	□	Arms
□	□	□	Dizziness	□	□	□	Neck Pain or Stiffness	□	□	□	Hands
□	□	□	Ear Infections	□	□	□	Nervousness/Depression	□	□	□	Hips
□	□	□	Earache/Ear Noises	□	□	□	Osteoporosis	□	□	□	Legs
□	□	□	Epilepsy	□	□	□	Pain Between Shoulders	□	□	□	Feet
□	□	□	Eye Pain	□	□	□	Sciatica				

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Patient Agreement

I hereby authorize the Doctor to treat my condition as he/she deems appropriate through the use of spinal manipulation throughout my spine. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any diagnosis.

If I have health insurance, I understand and agree that my insurance policy is an arrangement between an insurance carrier and myself. Although Dr. Darren W. Dubyak will file the insurance claims on my behalf, I am still responsible for all services rendered should my insurance company deny benefits. The patient or patient's guardian agrees that he/she is responsible for payment of all services rendered at this office.

It is understood and agreed that any amount paid for x-rays, is for production and analysis only and the x-ray films will remain the property of this office, as required by Pennsylvania State Law.

I certify that I have read and understood the above information and have provided accurate answers to the best of my ability. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child on a need to know basis to any third party payers and/or health practitioners.

Patient's Signature _____ Date _____

Guardian's Signature _____ Date _____