

**Brighton Campus Chiropractors, L.L.C.**  
**Dr. Louis Catapano, Dr. John Sciortino, Dr. Kevin Infantino**  
**2024 W. Henrietta Road, Suite 5B**  
**Rochester, NY 14623**  
**(585) 272-7340**

*The following information is necessary for our files. Please answer all questions completely.*

**List present complaint (Why are you here today):** \_\_\_\_\_

**On the line provided, please mark where your "pain" is today.**

0	5	10
No Pain	.	Most Severe pain

Social Security #: \_\_\_\_\_

**Name:** \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Employer:** \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_

Occupation: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

**In an Emergency, who may we contact:** \_\_\_\_\_ **Phone#:** \_\_\_\_\_

**DO YOU HAVE HEALTH INSURANCE? Yes** \_\_\_ **No** \_\_\_ **PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD.**

Insurance Company Name: \_\_\_\_\_ Contract #: \_\_\_\_\_

**Who is your Primary Care Physician?** \_\_\_\_\_

**FEMALES ONLY: Who is your OB/GYN Physician?** \_\_\_\_\_

**HOW DID YOU HEAR ABOUT OUR OFFICE?** \_\_\_\_\_

**IF RADIO, WHICH STATION?** \_\_\_\_\_

**E-MAIL ADDRESS?** \_\_\_\_\_

*I clearly understand and I agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care any fees for professional services rendered me will be immediately due and payable. If I have an insurance carrier, I understand that I am responsible for any deductible, any portion of the fee the carrier does not pay for, or if there is an unreasonable delay by the carrier or myself, I will be responsible for payment on request by this office. If this account is turned over to a lawyer, collection agency, or to the courts, I further agree to be responsible for the payment of all courts to this office for collection of services, including attorney fees, and the amount due is subject to the highest interest possible in this state.*

**Patient Name (Print):** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

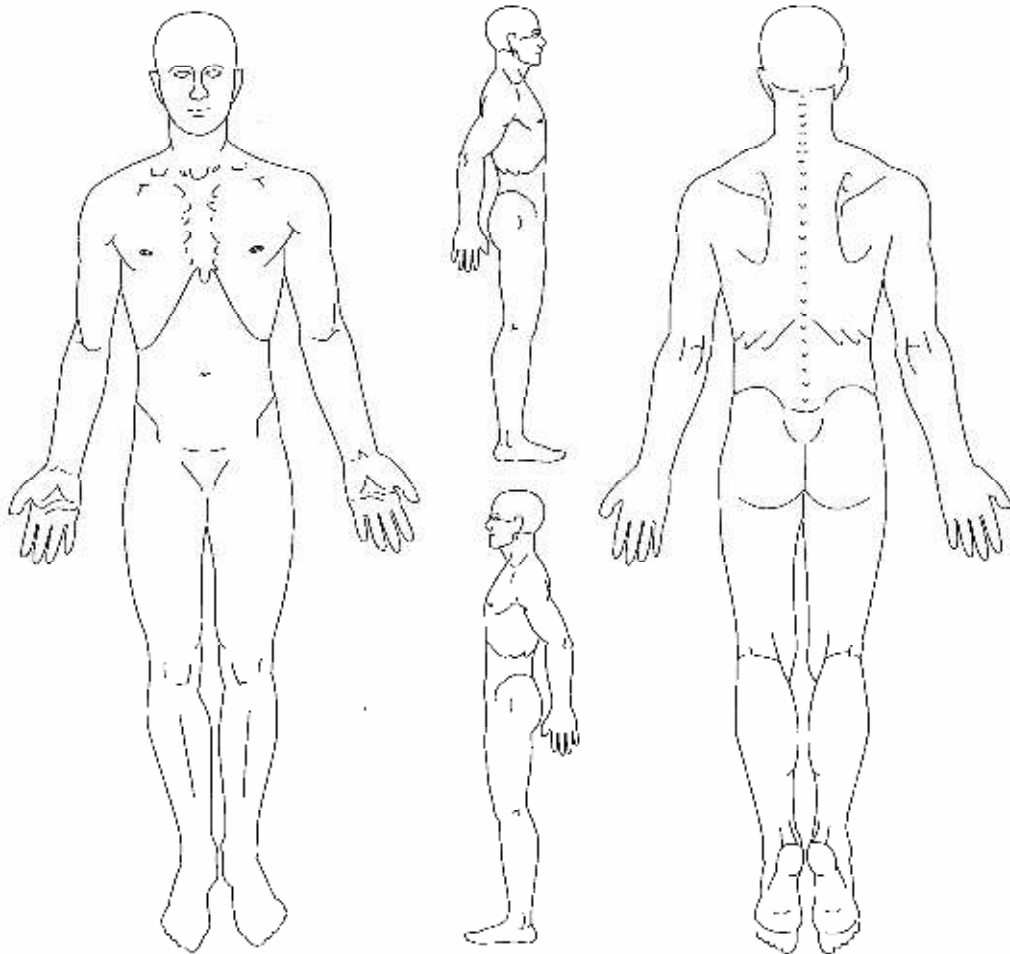
**Parent/Guardian Signature:** \_\_\_\_\_

Patient Name(Print) \_\_\_\_\_ Date \_\_\_\_\_

Patient ID # \_\_\_\_\_

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

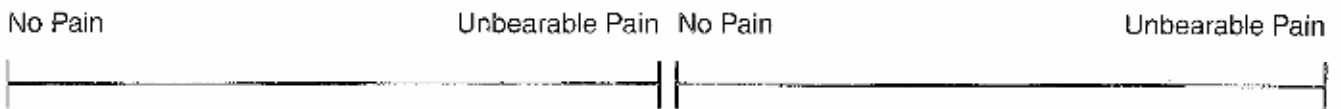
- D = Dull
- B = Burning
- N = Numb
- S = Stabbing/Cutting
- T = Tingling (Pins & Needles)
- C = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you have right now:

Rate your pain at its best in the past week:



Rate your average pain in the past week:

Rate your worst pain in the past week:

