PIETRANTONE HEALTH

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Dr. Luke Pietrantone • Dr. Michelle Pietrantone • Rebecca Greiner, LMSW

PERSONAL INFORMATION

Patient Name:		Name you wish to be called:	
Parent or Guardian Name (for children):			
Street Address:			
City:		State:	Zip:
Phone: | Cell:	Work:	E-Mail:	
Patient Date of Birth:		Gender: M / F	
Occupation:		Employer:	
Who were you referred by?			
Person to contact in case of emergency:		Phone:	

PRIMARY CONCERN

What brings you to my office?				
Date of original condition:			Date of most recent occurrence:	
Was there an event that created the condition?				
When this condition started, did you have any other health issues at that time?				
Where there significant life changes or stressors such as loss of a loved one, divorce, moving, travel, job related, new baby, etc at the time the condition started?				
What makes it better?				
What makes it worse?				
Is the condition getting worse?			Is the condition constant?	
Is it worse at a certain time of day?				
Is this condition interfering with:	Work?	Sleep?	Activity?	Other?
Please list your goals for treatment, (immediate and future), and if you are also concerned with optimizing your overall health and well-being:				

PRENATAL INTAKE

Total number of pregnancies you have had:	Total number of births you have had:
Name of midwife / birthcare provider:	
Name of doula:	
Are you registered for childbirth education? **Y N NA** If yes, where?	
Are you registered for breastfeeding education? **Y N NA** If yes, where?	
Have you received and vaccines during this pregnancy? (if so, please list):	Have you taken any medications during this pregnancy? (if so, please list):
Have you received ultrasounds during this pregnancy? **Y N** (if so,how many):	
Are you modifying your exercise for pregnancy/postpartum for any reason? **Y N NA** If yes, please describe:	

PLEASE FILL IN THE BELOW INFORMATION FOR EACH BIRTH YOU HAVE HAD.

BIRTH 1: Year_____ Current age of child_____ Duration of Gestation (wks)_____

Third Trimester Presentation: *Vertex*_____ *Breech*_____ *Transverse*_____ *Face/Brow*_____

Type of Birth: *Normal Vaginal*_____ *Forceps*_____ *Cesarean*_____ *Suction Cap or Vacuum*_____

Location: *Home*_____ *Birthing Center*_____ *Hospital*_____ *Other (Please specify)*_____

Was the baby injured during birth? **Y N** *If yes, please explain:*_____

Problems during prenancy:_____ Pain during prenancy:_____

Problems during labor/delivery:_____

Was your labor induced or accellerated in any way? **Y N** *If yes, please explain:*_____

APGAR Scores: _____ _____ Was there presence of: *Jaundacie (Yellow):* _____ *Cyanosis (Blue):* _____

Congentital Anomalies/Defects? **Y N** *If yes, please explain:*_____

Did the baby receive medication/vaccines at birth ? **Y N** *If yes, please explain:*_____

Did the baby go to the NICU / Stay in hospital ? **Y N** *If yes, please explain:*_____

Did you receive breastfeeding help? **Y N** *If yes, please explain:*_____

PRENATAL INTAKE CONTINUED (IF NEEDED)

PLEASE FILL IN THE BELOW INFORMATION FOR EACH BIRTH YOU HAVE HAD.

BIRTH 2: Year_____ Current age of child_____ Duration of Gestation (wks)_____

Third Trimester Presentation: *Vertex*_____ *Breech*_____ *Transverse*_____ *Face/Brow*_____

Type of Birth: *Normal Vaginal*_____ *Forceps*_____ *Cesarean*_____ *Suction Cap or Vacuum*_____

Location: *Home*_____ *Birthing Center*_____ *Hospital*_____ *Other (Please specify)*_____

Was the baby injured during birth? **Y N** *If yes, please explain:*_____

Problems during prenancy:_____ Pain during prenancy:_____

Problems during labor/delivery:_____

Was your labor induced or accellerated in any way? **Y N** *If yes, please explain:*_____

APGAR Scores: _____ _____ Was there presence of: *Jaundacie (Yellow):* _____ *Cyanosis (Blue):* _____

Congentital Anomalies/Defects? **Y N** *If yes, please explain:*_____

Did the baby receive medication/vaccines at birth ? **Y N** *If yes, please explain:*_____

Did the baby go to the NICU / Stay in hospital ? **Y N** *If yes, please explain:*_____

Did you receive breastfeeding help? **Y N** *If yes, please explain:*_____

BIRTH 3: Year_____ Current age of child_____ Duration of Gestation (wks)_____

Third Trimester Presentation: *Vertex*_____ *Breech*_____ *Transverse*_____ *Face/Brow*_____

Type of Birth: *Normal Vaginal*_____ *Forceps*_____ *Cesarean*_____ *Suction Cap or Vacuum*_____

Location: *Home*_____ *Birthing Center*_____ *Hospital*_____ *Other (Please specify)*_____

Was the baby injured during birth? **Y N** *If yes, please explain:*_____

Problems during prenancy:_____ Pain during prenancy:_____

Problems during labor/delivery:_____

Was your labor induced or accellerated in any way? **Y N** *If yes, please explain:*_____

APGAR Scores: _____ _____ Was there presence of: *Jaundacie (Yellow):* _____ *Cyanosis (Blue):* _____

Congentital Anomalies/Defects? **Y N** *If yes, please explain:*_____

Did the baby receive medication/vaccines at birth ? **Y N** *If yes, please explain:*_____

Did the baby go to the NICU / Stay in hospital ? **Y N** *If yes, please explain:*_____

Did you receive breastfeeding help? **Y N** *If yes, please explain:*_____

BIRTH 4: Year_____ Current age of child_____ Duration of Gestation (wks)_____

Third Trimester Presentation: *Vertex*_____ *Breech*_____ *Transverse*_____ *Face/Brow*_____

Type of Birth: *Normal Vaginal*_____ *Forceps*_____ *Cesarean*_____ *Suction Cap or Vacuum*_____

Location: *Home*_____ *Birthing Center*_____ *Hospital*_____ *Other (Please specify)*_____

Was the baby injured during birth? **Y N** *If yes, please explain:*_____

Problems during prenancy:_____ Pain during prenancy:_____

Problems during labor/delivery:_____

Was your labor induced or accellerated in any way? **Y N** *If yes, please explain:*_____

APGAR Scores: _____ _____ Was there presence of: *Jaundacie (Yellow):* _____ *Cyanosis (Blue):* _____

Congentital Anomalies/Defects? **Y N** *If yes, please explain:*_____

Did the baby receive medication/vaccines at birth ? **Y N** *If yes, please explain:*_____

Did the baby go to the NICU / Stay in hospital ? **Y N** *If yes, please explain:*_____

Did you receive breastfeeding help? **Y N** *If yes, please explain:*_____

PRENATAL INTAKE CONTINUED (IF NEEDED)

PLEASE FILL IN THE BELOW INFORMATION FOR EACH BIRTH YOU HAVE HAD.

BIRTH 5: Year_____ Current age of child_____ Duration of Gestation (wks)_____

Third Trimester Presentation: *Vertex*_____ *Breech*_____ *Transverse*_____ *Face/Brow*_____

Type of Birth: *Normal Vaginal*_____ *Forceps*_____ *Cesarean*_____ *Suction Cap or Vacuum*_____

Location: *Home*_____ *Birthing Center*_____ *Hospital*_____ *Other (Please specify)*_____

Was the baby injured during birth? **Y N** *If yes, please explain:*_____

Problems during prenancy:_____ Pain during prenancy:_____

Problems during labor/delivery:_____

Was your labor induced or accellerated in any way? **Y N** *If yes, please explain:*_____

APGAR Scores: _____ _____ Was there presence of: *Jaundacie (Yellow):* _____ *Cyanosis (Blue):* _____

Congentital Anomalies/Defects? **Y N** *If yes, please explain:*_____

Did the baby receive medication/vaccines at birth ? **Y N** *If yes, please explain:*_____

Did the baby go to the NICU / Stay in hospital ? **Y N** *If yes, please explain:*_____

Did you receive breastfeeding help? **Y N** *If yes, please explain:*_____

BIRTH 6: Year_____ Current age of child_____ Duration of Gestation (wks)_____

Third Trimester Presentation: *Vertex*_____ *Breech*_____ *Transverse*_____ *Face/Brow*_____

Type of Birth: *Normal Vaginal*_____ *Forceps*_____ *Cesarean*_____ *Suction Cap or Vacuum*_____

Location: *Home*_____ *Birthing Center*_____ *Hospital*_____ *Other (Please specify)*_____

Was the baby injured during birth? **Y N** *If yes, please explain:*_____

Problems during prenancy:_____ Pain during prenancy:_____

Problems during labor/delivery:_____

Was your labor induced or accellerated in any way? **Y N** *If yes, please explain:*_____

APGAR Scores: _____ _____ Was there presence of: *Jaundacie (Yellow):* _____ *Cyanosis (Blue):* _____

Congentital Anomalies/Defects? **Y N** *If yes, please explain:*_____

Did the baby receive medication/vaccines at birth ? **Y N** *If yes, please explain:*_____

Did the baby go to the NICU / Stay in hospital ? **Y N** *If yes, please explain:*_____

Did you receive breastfeeding help? **Y N** *If yes, please explain:*_____

HEALTH HISTORY

List other current health issues & problems:

List other practitioners seen, treatments, self-care activities, and results:

Blood work results:

List all surgeries you have had, with dates and results:

Have you ever been in an accident or seriously injured? (if so, please describe):

Do you have any dental or TMJ problems? **Y N** (if so, please describe):

Do sleeping patterns seem normal? **Y N** (if not, please describe):

Does digestion seem normal? Excess gas/reflux? **Y N** (if not, please describe):

Have you taken antibiotics in the last year? **Y N** (if so, please explain):

Have you had vaccinations in the last year? **Y N** (if so, please explain):

List all medications, vitamins, herbs and other supplements you are now taking, the dose, and reason for taking:

List all medications and other substances (i.e.: foods) to which you are allergic:

FAMILY HISTORY

Please list age(s) and health problems (if any). If deceased, please list age at death and cause of death.

Father:

Mother:

Children:

Grandparents:

Brothers:

Sisters:

GENERAL

Describe your present exercise habits including frequency per week, duration, and heart rate:

Type of sport(s) /activity / exercise routine you participate in:

Hours you train/exercise average per week:	Do you train by yourself or with others?
Do you use a heart rate monitor? **Y N**	What type of shoes do you wear? (Name / Style)

Describe your job activities (stress levels) and hours of work per week:

Is there traveling associated with your job? If yes, please describe.

Is your job physical or are you sitting at a computer?

PAIN QUESTIONAIRE

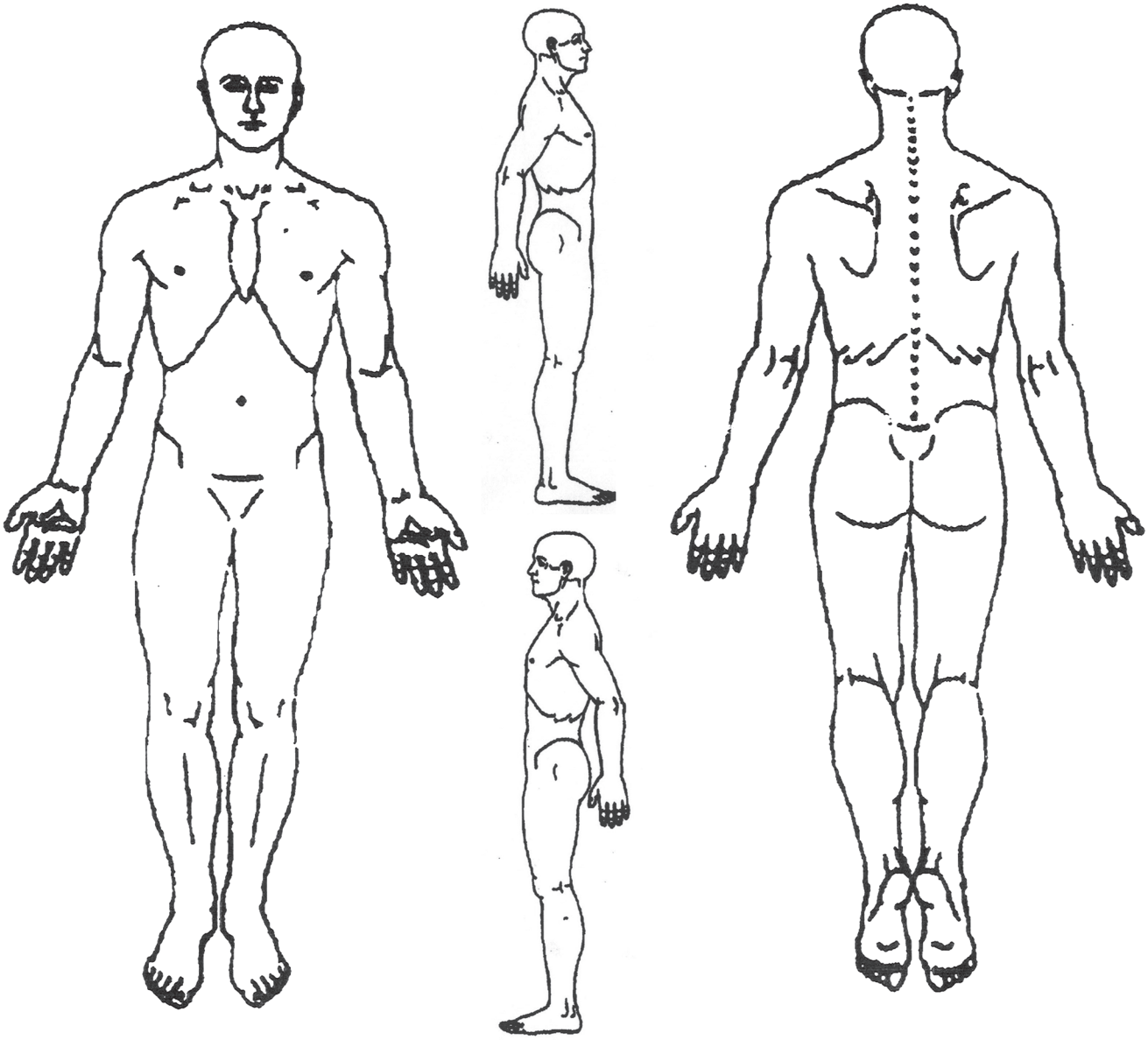
Skip to the next section if you are not currently experiencing pain.

Please place a single vertical line through the scale below at the point that best describes your pain.
(0 is no pain, 10 is the worst pain imaginable)

0.....|.....|.....|.....|.....|.....|.....|.....|.....|.....10

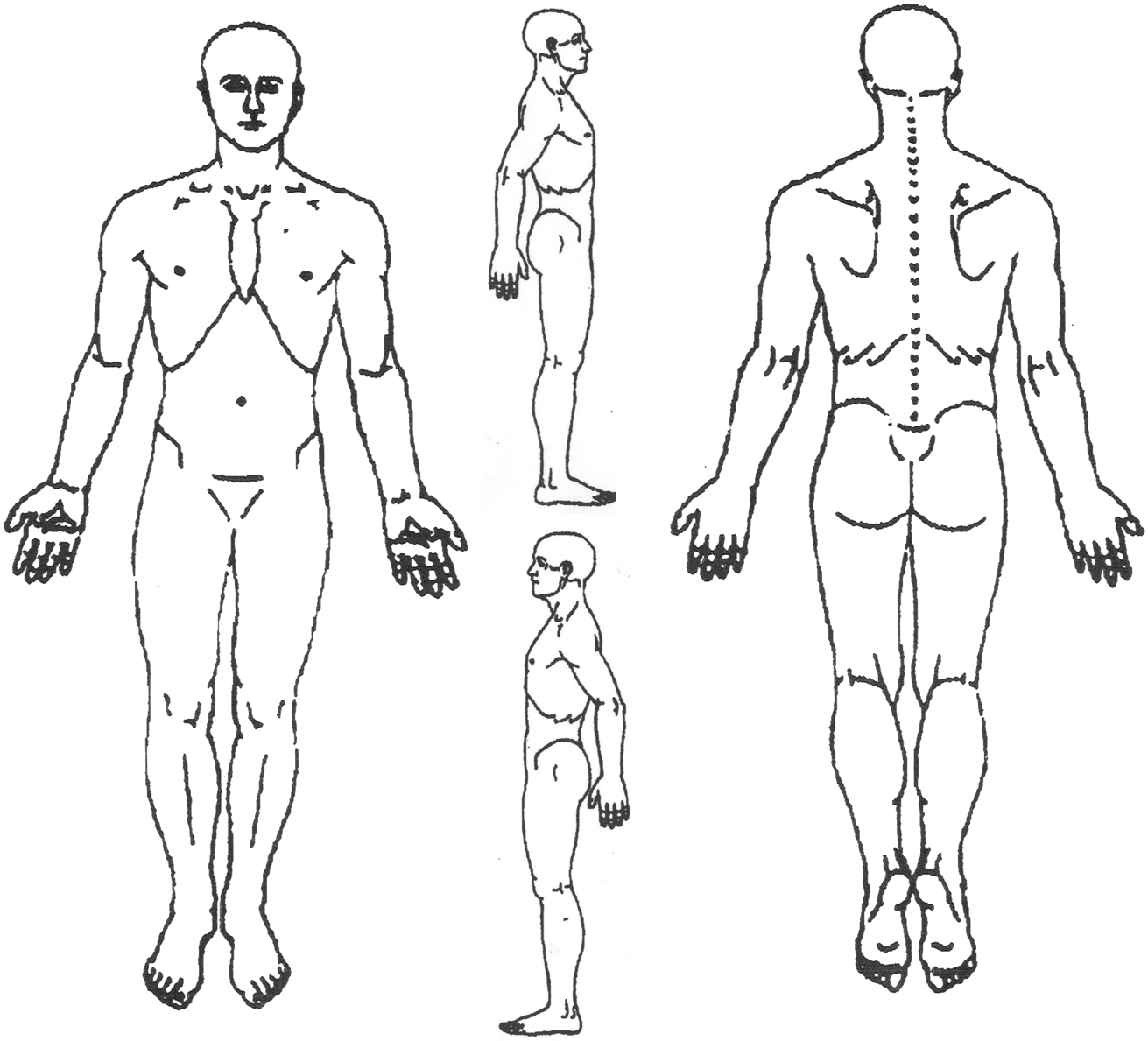
Place the letters listed below on the diagrams to indicate the type and location of your current sensations.

A = Ache B = Burning N = Numbness O = Other P = Pins & Needles S = Stabbing T = Throbbing



HISTORY OF INJURY

Please mark with an "X" **all the places on your body which have ever been injured** (sprains, strains, broken bones, scars from surgeries or accidents, severe bruises, falls, etc.). Please also include any tattoos and piercings, other than ear.



DIET HISTORY

How much do you drink each day (8oz):			
Water:	Juice:	Diet Soda:	Regular Soda:
Regular Coffee:	Decaf Coffee:	Regular Tea:	Sweet Tea:
Energy Drinks/Other:		Alcohol:	

List oils or fats that you use in cooking:

Do you frequently skip meals? **Y N**	Have you increased your protein intake? **Y N**

Are you on any special diet or nutrition program? **Y N**
Describe:

Are you allergic or sensitive to any foods? **Y N** / If yes, name the foods and describe the problem.

What foods do you dislike?

What is/are your favorite food(s)?

Circle the foods you crave:
Meats Fats Sweets Salty Foods Vegetables Fruits Breads Fatty Foods Spicy foods Sour Foods Cereals Dairy
Other individual:

Circle: Do you use?... butter margarine shortening coconut oil	Do you eat organic foods? **Y N**

Do you know what partially hydrogenated fats are? **Y N** / If yes, do you eat them? **Y N**

Do you eat from fast food restaurants? **Y N** / If yes, how often?

What do you usually eat for breakfast?

What do you usually eat for lunch?

What do you usually eat for dinner?

What do you usually eat for snacks (in between meals and/or before bed)?

What foods do you eat a lot of (at least once a day, every day)?

How many bowel movements do you have per day?	Are your bowel movements hard, firm or loose?

OFFICE POLICIES

Dr. Luke Pietrantone and Dr. Michelle Pietrantone are Chiropractors, and not medical or osteopathic physicians. As a result, this practice and the care provided is limited to that which is permitted by State Law. We do not provide the type of care or treat conditions that fall within the scope of practice of Medical Doctors, and do not treat or offer cures for diseases or illnesses, only supportive advice and therapies.

Psychotherapy and Neurofeedback Services

Rebecca Greiner, LMSW, provides psychotherapy and neurofeedback services within the parameters of New York State regulations. Please note that we do not provide any diagnostic services or mental health diagnoses. These services are intended to support your mental and emotional well-being but are not covered or reimbursable by insurance. Clients seeking these services should understand that payments will be required out-of-pocket. Please inquire about the current rates for psychotherapy and neurofeedback services when scheduling.

Financial

This practice does not participate (not in-network) with any insurance. We will provide you with a receipt with the appropriate diagnosis codes and procedure codes upon request to the front desk for chiropractic visits only. We are unable to fill out any paperwork for approvals, authorizations, etc. Patients may opt to submit this to their insurance on their own. However, any reimbursement depends solely on your insurance plan's coverage and limits.

All payments for appointments are due at the time of the visit. We accept all major credit cards, FSA cards, HSA cards, cash and checks.

All supplements and additional supplies are the patient's responsibility and payment is due at the time of the visit.

Please give our office at least 24 hours advance notice for any cancellation. If 24 hours notice is not given, 50% of the appointment fee will be billed to you. You will not be able to schedule subsequent appointments if you have an outstanding no-show balance.

Emergencies

If you have a medical emergency and are unable to contact us through the office phone, 716-655-1421, please go to the Emergency Room or dial 911.

For mental health emergencies, please contact **Crisis Services in Buffalo** at 716-834-3131. This service is available 24/7 and can provide immediate assistance in cases of mental health crises, suicidal thoughts, or other urgent emotional distress. For further support, you may also call the National Suicide Prevention Lifeline at **988**.

Confidentiality

We will never sell your information such as emails or phone numbers. Any requests for documentation by doctors, family, and insurance companies will require your written consent.

By signing below you understand and agree to the above office policies including the 24-hour cancelation fee. Bring this form to your first appointment. We cannot begin treatment without it.

_____

Name (printed)

_____

Name (signed)

_____

Date

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