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NEW PATIENT INFORMATION

Name ____

Date of First Visit __________________________________

Address ____

City_________________ **State** _____ **Zip** ___________

Home phone _________________ **Birth date** _________

Cell phone ____________________ **Age** _______________

Gender _________ **Age** ____ **Number of children** _______

Marital Status ____________________________________

Employer ____

Work address ______________________________________

Work phone _______________________________________

Type of work ______________________________________

E-mail address_____________________________________

Payment method for first visit:

❑ Cash ❑ Check ❑ Credit card

Insurance Type

❑ Auto Accident ❑ Work Injury ❑Health/Commercial

Insurance Company _______________________________

REASON FOR THIS VISIT

Current Health Complaints/Reasons for consulting our office.

1. ____
2. ____
3. ____

When did this condition begin? ___________________

Has this condition occurred before? ❑ Yes ❑ No

Briefly describe your symptoms: __________________________

____

How did your symptoms start? ____________________________

____

Average Pain Intensity: please circle one

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

How often do you experience your symptoms?

❑ Constant (76-100% of the time) ❑ Frequent (51-75% of the time)

❑ Occasional (26-50% of the time) ❑ Intermittent (0-25% of the time)

How much have your symptoms interfered with your daily activities?

❑ Not at all ❑ A little bit ❑ Moderately ❑ Quite a bit ❑ Extremely

In general, would you say your overall health right now is:

❑ Excellent ❑ Good ❑ Fair ❑ Poor

Have you seen other doctors for this condition? ❑ Yes ❑ No

Type of treatment and results________________________________

____

____

EMERGENCY CONTACT

Name ____

Employer ____

Work phone ______________________________________

Type of work _____________________________________

EXPERIENCE WITH CHIROPRACTIC

Who may we thank for referring you to this office? ____________________

Have you been adjusted by a Chiropractor before? ❑ Yes ❑ No

Reason for those visits? ____

Doctor's name____

Approximate date of last visit ____________________________________

Has any adult in your family seen a Chiropractor? ❑ Yes ❑ No

Has any child in your family seen a Chiropractor? ❑ Yes ❑ No

General Questions

- Does your mother, father, brother, sister, children have similar problems? ❑ Yes ❑ No
- Do you have a history of cancer? ❑ Yes ❑ No
- Do you have a history of corticosteroid (injected pain medication) use? ❑ Yes ❑ No
- Have you experienced in the past, or do you have, bowel and bladder problems? ❑ Yes ❑ No

CURRENT MEDICATIONS

- ❑ Nerve pills
- ❑ Stimulants
- ❑ Tranquilizers
- ❑ Muscle relaxers
- ❑ Insulin
- ❑ Blood pressure medicine
- ❑ Blood thinners
- ❑ Pain killers (including aspirin)
- ❑ ____________________
- ❑ ____________________

Childhood Illnesses __________________________
____

HEALTH HABITS

	No	Yes
Do you smoke?	❑	❑ ____ packs/day
Do you drink alcohol?	❑	❑ ____ drinks/day
Do you drink coffee?	❑	❑ ____ cups/day

Do you exercise regularly? ❑ No ❑ Moderate ❑ Daily

Do you wear ❑ Heel lifts ❑ Sole lifts ❑ Inner soles ❑ Arch supports

HEALTH CONDITIONS

Please check each of the diseases or conditions that you have now, have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

- ❑ Severe or frequent headaches
- ❑ Sinus problems
- ❑ Dizziness
- ❑ Loss of sleep
- ❑ Pain b/w shoulders
- ❑ Frequent neck pain
- ❑ Numb in arms/legs/hand
- ❑ Tuberculosis
- ❑ Pain in arms/legs/hand
- ❑ Surgeries
- ❑ Digestive problems
- ❑ Heart surgery/ pacemaker
- ❑ Heart attack/stroke
- ❑ Heart murmur
- ❑ Congenital heart defect
- ❑ High/Low blood pressure
- ❑ Difficulty breathing
- ❑ Asthma
- ❑ Psychiatric problems
- ❑ Alcohol/drug abuse
- ❑ Lower back problems
- ❑ Ulcers/Colitis
- ❑ Arthritis
- ❑ Diabetes
- ❑ Shingles
- ❑ Kidney problems
- ❑ Hepatitis
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Rheumatic fever
- ❑ Thyroid problems
- ❑ Venereal disease
- ❑ HIV/AIDS
- ❑ _____________
- ❑ _____________

For women:

Are you pregnant? ❑ Yes ❑ No
Are you nursing? ❑ Yes ❑ No
Are you taking birth control? ❑ Yes ❑ No
Do you experience painful periods? ❑ Yes ❑ No
Do you have irregular cycles? ❑ Yes ❑ No
Do you have breast implants? ❑ Yes ❑ No

Allergies

❑ None known
____
____

Vaccinations

❑ Current _________
❑ Exempt ____________
____

Hospitalizations

____
____
____

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

Patient's Signature______________________________ Date__________________

Guardian or Spouse's Signature Authorizing Care ____________________________ Date ____________

Who should receive bills for payment on your account?

___ Patient ___ Spouse ___ Parent ___ Worker's Comp ___ Auto Insurance
___ Medicare ___ Medicaid ___ Personal Health Insurance