OFFICE USE ONLY
Date: _____
Dr. Signature:_____

# New Patient Information Form

## Patient Information:

Name _____Nickname _____

Address _____City_____State_____Zip_____

Phone (Cell) _____ (H) _____ (W) _____

Email Address_____

Date of Birth _____ Age _____ Social Security # _____

Marital Status: ___Single ___Married ___Divorced ___Widow

Occupation _____ Place of employment_____

Spouse's Name _____ Spouse's Occupation __ _____

Emergency Contact _____ Phone _____

Number of Children _____ Ages _____

How did you hear about our office? _____

If referral, please tell us who: _____

Where did you get our phone number? _____

Have you and your family ever received Chiropractic Care? ___Yes ___ No

Have you been receiving Chiropractic Care since this January in another office? ___Yes ___No

If you answer YES, please tell us how many times you have been to another office before here:

## Insurance Information:

Do you have Insurance? ___Yes ___No

Name of Company _____ Phone _____

Primary Policy Holder's Name _____

ID # _____

*If an auto accident or worker's comp, please provide:

Nature of Injury: ___Automobile* ___Work* ___Other

Insurance Company Name _____Contact Person _____

Phone _____ Claim # _____

## Signatures:

Name of Financially Responsible Party_____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature _____ Date _____

Parent/Guardian's Signature _____ Date _____

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# Health Status

Yes No - Difficult delivery (circle): Forceps C-Section Breach/Cephalic Lengthy

Other: _____

Yes No - Hospital birth? _____

Yes No - Chiropractic adjustment within 1st year of life? Age _____

Yes No - Were you breastfed? _____

Yes No - Were you a repetitive head banger or rocker as a child?_____

Yes No - Childhood Illnesses? _____

Yes No - Child Abuse? _____ Spanking? _____ Pulled ear/chin _____

Yes No - Physical Traumas?

Car accidents: List _____

Slips/Falls: List _____

Other: _____

Yes No - Played any sports? Which? _____

Yes No - Injuries during sports? _____

Yes No - Broken Bones? _____

Yes No - Surgeries? _____

Yes No - Medications as a child? _____

Yes No - Current Illnesses? _____

Yes No - Hospitalizations? _____

Yes No - Do you exercise regularly? Explain _____

Yes No - Do you eat healthy foods (circle): always mostly sometimes not enough

Yes No - Current Supplements: List _____

_____

Yes No - Current Medications: List _____

_____

Yes No - Do you drink alcohol? How much/often? _____

Yes No - Stress? Explain _____

Yes No - Do you sleep well? How many hours per night? _____

Sleeping Posture (circle): side back stomach couch chair

Yes No - Do you drive a lot? How much time driving per day? _____

Yes No - Do you sit at a Computer? How many hours/minutes per day? _____

Yes No - If female, any chance you are pregnant? ___ I am a male

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## Past/Current Symptoms (circle "P" for Past and "C" for Current)

| | | | |
|---|---|---|---|
| ADD/ADHD (P/C) | Chest Pain (P/C) | Dizziness/Balance (P/C) | Numbness (arms/legs) (P/C) |
| Allergies (P/C) | Cold Hands/Feet (P/C) | Ear Infections (P/C) | Pins/Needles (arms/legs) (P/C) |
| Anemia (P/C) | Cold Sweats/Fever (P/C) | Ears Ringing/Buzzing (P/C) | Pacemaker (P/C) |
| Arthritis (P/C) | Colic (P/C) | Fatigue (P/C) | Poor Posture (P/C) |
| Asthma (P/C) | Constipation (P/C) | Headaches/Migraines (P/C) | Prostate Trouble (P/C) |
| Atherosclerosis (P/C) | Cramps (P/C) | High Blood Pressure (P/C) | Sciatica (P/C) |
| Back Pain (P/C) | Depression (P/C) | Infertility Problems (P/C) | Sinus Infections (P/C) |
| Bed Wetting (P/C) | Diabetes (I or II) (P/C) | Irregular Heartbeat (P/C) | Sleeping Problems (P/C) |
| Bruise Easily (P/C) | Diarrhea (P/C) | Irregular Periods (P/C) | Stroke (P/C) |
| Cancer (P/C) | Digestion Problems (P/C) | Neck Pain/Stiffness (P/C) | Thyroid Condition (P/C) |

Others Symptoms: _____

1st Area of Complaint: ___Neck ___Mid-back ___Low-back

2nd Area of Complaint: ___Neck ___Mid-back ___Low-back

3rd Area of Complaint: ___Neck ___Mid-back ___Low-back

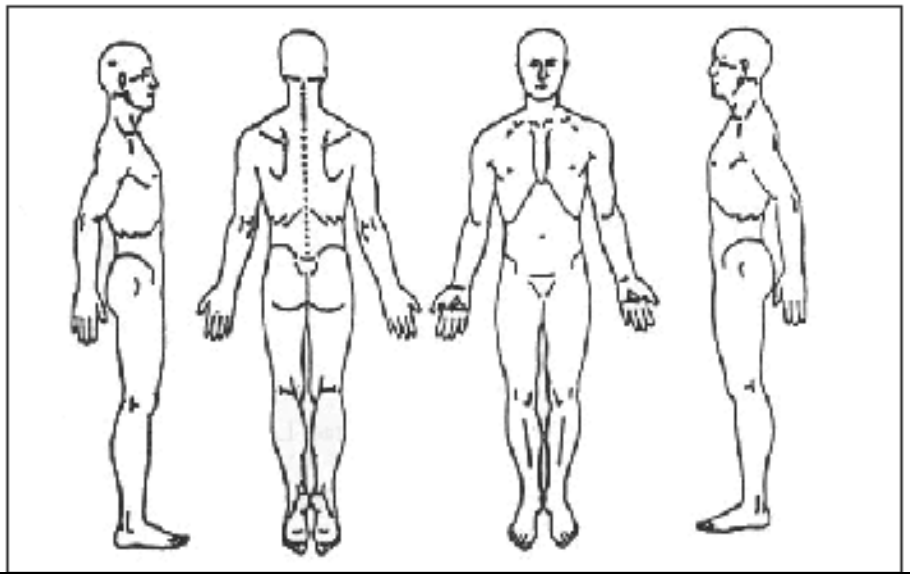
Non-spinal Complaint(s): _____

What caused the injury/pain:_____

_____

Check if here for Wellness care ____

Using the symbols below, mark on the pictures where you feel pain



| | |
|---|---|
| Numbness | = = = |
| Dull Ache | OOO |
| Burning | XXX |
| Sharp/Stabbing | / / / |
| Pins/Needles | + + + |
| Other _____ | ^ ^ ^ |