



Welcome to our office! Please complete all questions completely and accurately!

### NEW PATIENT INFORMATION

Name \_\_\_\_\_
Date of First Visit \_\_\_\_\_
Address \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Phone # \_\_\_\_\_ Birth date \_\_\_\_\_
Phone # where a message may be left \_\_\_\_\_
Gender \_\_\_\_\_ Age \_\_\_\_\_ Number of children \_\_\_\_\_
Race \_\_\_\_\_
Employer \_\_\_\_\_
Work address \_\_\_\_\_
Work phone \_\_\_\_\_
Type of work \_\_\_\_\_
Marital Status \_\_\_\_\_
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?
[ ] Constantly (76%-100% of the time) [ ] Frequently (51%-75% of the time)
[ ] Occasionally (26% - 50% of the time) [ ] Intermittently (0%-25% of the time)
How much have your symptoms interfered with your usual 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/SPOUSE INFORMATION

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 use? [ ] Yes [ ] No
Have you experienced in the past, or do you have, bowel and bladder problems? [ ] Yes [ ] No

# GOALS FOR MY CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your program of care. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Relief care – Symptomatic relief of pain or discomfort
- Corrective care – Correcting and relieving the cause of the problem as well as the symptoms
- Comprehensive care – Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care
- I want the Doctor to select the type of care appropriate for my condition.

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Date

## MEDICATIONS I NOW TAKE

- Nerve pills
  - Stimulants
  - Tranquilizers
  - Muscle relaxers
  - Insulin
  - Childhood Illnesses \_\_\_\_\_
- Blood pressure medicine
  - Blood thinners
  - Pain killers (including aspirin)
  - \_\_\_\_\_
  - \_\_\_\_\_

## HEALTH HABITS

- |                            | No                                   | Yes  |
|----------------------------|--------------------------------------|--|
| Do you smoke?              | <input type="checkbox"/>             | <input type="checkbox"/> ____ packs/day                          |
| Do you drink alcohol?      | <input type="checkbox"/>             | <input type="checkbox"/> ____ drinks/day                         |
| Do you drink coffee?       | <input type="checkbox"/>             | <input type="checkbox"/> ____ cups/day                           |
| Do you exercise regularly? | <input type="checkbox"/> No          | <input type="checkbox"/> Moderate <input type="checkbox"/> Daily |
| Do you wear                | <input type="checkbox"/> Heel lifts  | <input type="checkbox"/> Sole lifts                              |
|                            | <input type="checkbox"/> Inner soles | <input type="checkbox"/> 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.

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Severe or frequent headaches | <input type="checkbox"/> Heart surgery/<br>pacemaker | <input type="checkbox"/> Arthritis            |  |
| <input type="checkbox"/> Sinus problems               | <input type="checkbox"/> Heart attack/stroke         | <input type="checkbox"/> Diabetes             | For women:   |
| <input type="checkbox"/> Dizziness                    | <input type="checkbox"/> Heart murmur                | <input type="checkbox"/> Shingles             | Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No                     |
| <input type="checkbox"/> Loss of sleep                | <input type="checkbox"/> Congenital heart defect     | <input type="checkbox"/> Kidney problems      | Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No                      |
| <input type="checkbox"/> Pain between shoulders       | <input type="checkbox"/> High/Low blood pressure     | <input type="checkbox"/> Hepatitis            | Are you taking birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No         |
| <input type="checkbox"/> Frequent neck pain           | <input type="checkbox"/> Difficulty breathing        | <input type="checkbox"/> Cancer               | Do you experience painful periods?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Numbness in Arms/legs/hands  | <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Chemotherapy         | Do you have irregular cycles?<br><input type="checkbox"/> Yes <input type="checkbox"/> No      |
| <input type="checkbox"/> Pain in Arms/legs/hands      | <input type="checkbox"/> Tuberculosis                | <input type="checkbox"/> Rheumatic fever      | Do you have breast implants?<br><input type="checkbox"/> Yes <input type="checkbox"/> No       |
| <input type="checkbox"/> Lower back problems          | <input type="checkbox"/> Alcohol/drug abuse          | <input type="checkbox"/> Psychiatric problems |  |
| <input type="checkbox"/> Digestive problems           | <input type="checkbox"/> Venereal disease            | <input type="checkbox"/> Thyroid problems     |  |
|   | <input type="checkbox"/> HIV/AIDS                    | <input type="checkbox"/> Surgeries            |  |
|   | <input type="checkbox"/> Ulcers/Colitis              | <input type="checkbox"/> _____                |  |
|   |  | <input type="checkbox"/> _____                |  |

### 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

### Ownership of X-ray Films.

It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient of this office.