New Patient Registration & History

Date: _____ **Name:** _____
First M/I Last

Address: _____
House No. Apt. Street City State Zip Code

Phone: (H) _____ (C) _____ **Circle Preferred Contact #**

Social Security No.: _____ **Sex:** _____ **Date of Birth:** _____ **Age:** _____

Email: _____ **Whom may we thank for referring you?** _____

Occupation: _____ **Employer:** _____

Marital Status (circle): **Single** **Married** **Widowed** **Divorced** **Separated**

(If Applicable) Spouse's Name: _____ **Spouse's Date of Birth:** _____

Spouse's Occupation: _____ **Spouse's Employer:** _____

Emergency Contact: _____
Name **Phone No.** **Relationship**

Insurance Coverage (if none, write cash): Primary: _____

Secondary: _____ **Do you have an HSA card or HRA fund? (if yes, please circle)**

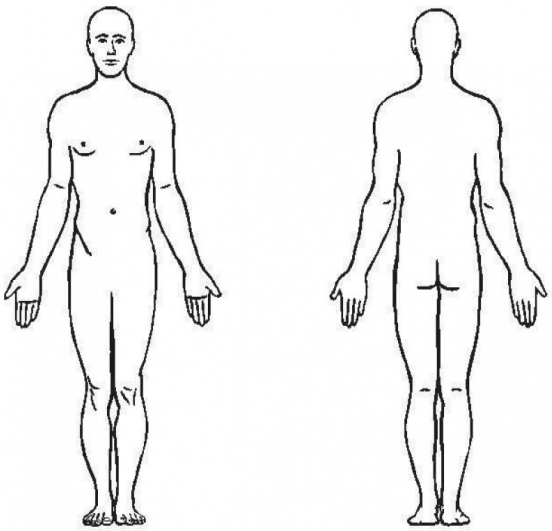
Reason for visit: _____

When did your symptoms begin? _____

Is it getting progressively worse? (circle) Yes No

Do you ever experience pelvic or groin pain? (circle) Yes No
(including menstrual related)

Mark the picture (right) with an X where you continue to have pain, numbness, or tingling. ----------->>>>>



Rate the severity of your pain on a scale from 1 (minor) to 10 (severe) _____

Type(s) of pain: (circle) sharp dull throbbing numbness aching shooting burning tingling cramps stiffness swelling other _____

Is the pain constant? Yes No

If it comes and goes, how frequently? _____

Does it interfere with: work sleep daily routine recreation
sitting standing walking bending lying down

OVER

Have you ever seen a chiropractor before? **No** **Yes** If yes, who? _____
What treatment have you already received for this condition? (circle) **medications** **surgery** **physical therapy** **chiropractic services** **none** **other:** _____
Name and phone of other doctor(s) who have treated this condition: _____
_____
Date of 1st treatment: _____ Number of treatments in last 12 months: _____
Primary Care Doctor:_____ Phone: _____
Date of last: physical exam _____ spinal x-ray _____ blood test _____
spinal exam _____ chest xray _____ MRI/CT/Bone Scan _____
Circle symptoms you currently have: balance impairment headaches loss of memory vertigo burning eyes light headedness nausea visual disturbance depression loss of concentration ringing/buzzing in ears other: _____
Circle or check conditions or symptoms you have or have had in the past:

AIDS/HIV	diabetes	jaw pain/TMJ	rheumatoid arthritis
anemia	emphysema	kidney disease	rheumatic fever
anorexia	epilepsy	liver disease	scarlet fever
appendicitis	glaucoma	mononucleosis	stroke
arthritis	goiter	multiple sclerosis	thyroid problems
asthma	gout	osteoporosis	tuberculosis
blood clots	heart disease	pacemaker	tumors/growths
breast lump	hepatitis	Parkinson's disease	ulcers
bronchitis	hernia	pinched nerve	varicose veins
bulimia	herniated disc	pneumonia	whiplash
cancer	herpes	polio	other: _____
cataracts	high blood pressure	prosthesis	
chemical dependency	high cholesterol	psychiatric care	

Exercise: none daily moderate heavy **Work Activity :** sitting standing light labor heavy labor
Pregnant? No Yes, due date _____ **Do you smoke?** How much? _____ **Alcoholic drinks/week?**_____
Coffee/caffeine cups/day? _____ High stress level? Reason: _____
Any history of: **accidents/falls** **head injuries** **broken bones** **dislocations** **surgeries**
If yes, please describe injury/date: _____
_____

Medications	**Allergies**	**Vitamins/Supplements**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Checking eligibility and/or benefit information is not a guarantee of payment. Benefits will be determined upon receipt of a claim by your insurance company and will be based upon, among other things, the member's eligibility and the terms of the member's coverage; including, but not limited to, limitations and exclusions on the date(s) services were rendered. If services are determined to be not covered by insurance, payment is patient's responsibility. Late fees will be added after 30 days.
*****Payment is due at time of service*****

I certify that the information I have provided is accurate and complete to the best of my knowledge. I acknowledge I am responsible for any deductible, copay, or coinsurance amounts my insurance may require.

X_____ Date: _____
Patient or Guardian Signature