New Patient Information

Date: _____ Patient #: _____

Patient Information:

Name: _____ Date of Birth: _____
Current Address: _____
Home Phone: _____ Cell Phone: _____
Email address: _____ Marital Status: S/ M/ D/ W SS#: _____
Employer: _____ Work Phone: _____ Occupation: _____
Address: _____

Spouse's Name: _____ Occupation: _____
Employer: _____

How many children: _____ Children's Name: _____
_____
_____

How were you referred to our office: _____
Family Medical Doctor: _____ Telephone:_____

History of Present Illness:

Chief Complaint: Purpose of this appointment: _____
Date symptoms appeared or accident happened: _____
Is this due to: ____ Auto Accident ___Work Related Other_____
Have you ever had the same or a similar condition: ___Yes / ___No
If yes, when and describe:_____
Days lost from work: _____ Date of last physical examination: _____

Past Medical History:

Have you ever been diagnosed as having or suffered from:

___ Hypertension	___Osteoarthritis	___ Eating Disorder	___Epilepsy
___ Rheumatoid Arthritis	___ Alcoholism	___ Pace Maker	___ Strokes
___ Seizures/Convulsions	___ Drug Addition	___ Cancer	___ Hernia
___ Congenital Disease	___ HIV Positive	___ Depression	___ Ulcers
___Excessive Bleeding	___ Gall Bladder Surgery	___ Coughing Blood	___ Circulatory Issues
___ High/Low Blood Pressure		___ Broken or Fractured Bones	

Patient Name: _____ Patient #: _____

Have you had any major illness, injuries, falls, auto accident(s) or surgeries: ___Yes / ___No

If yes: _____

_____

Have you been treated for any health condition in the last year: ___Yes / ___No

If yes: _____

_____

What medication are you taking:

_____

_____

_____

Please list any allergies:

_____

_____

Please list any other health problems you have, no matter how insignificant they may be: _____

_____

_____

Social History:

Do you Drink alcohol	___Yes / ___No	If yes, how much per week: _____
Do you smoke or use tobacco	___Yes / ___No	If yes, how much per day: _____
Do you take vitamin supplements	___Yes / ___No	If yes, list: _____
		_____
Do you consume caffeine	___Yes / ___No	If yes, how much daily: _____
Do you exercise	___Yes / ___No	If yes, what is the frequency: _____ and what type: _____

What are your hobbies: _____

_____

What percentage of the time during the day (at home/at work/away from home) do you spend:

____ Lifting ____ Sitting ____ Bending ____ Working at a computer

Patient Name: _____ Patient #: _____

Family History:

Parents: Father is - living_____ deceased_____ Current age if still living: _____

Cause of death if deceased _____

Mother is- living_____ deceased_____ Current age if still living: _____

Cause of death if deceased _____

_____ Adopted, little is known of birth parents

Family Diseases, please indicate: **F**ather, **M**other, **S**ister or **B**rother

___ Tuberculosis ___ Cancer ___ Mental Illness ___ Diabetes ___ Asthma

___ Heart Disease ___ Stroke ___ Kidney Disease ___ Lung Disease ___ Arthritis

___ Liver Disease ___ Scoliosis Other: _____

Insurance Information:

Insurance Company: _____ Type of coverage: _____

Policy or SSN#: _____ Group#: _____

Insured's Name: _____ Relation to patient: _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the treating physician(s) office. I authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers or payors to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend/terminate my schedule of care as determined by my treating physician, any fees for professional services will be immediately due and payable. Fees are payable at the time x-rays, examinations, treatment(s) are received, unless other arrangements are made in advance. X-rays remain the property of this clinic. Duplication of original films are available for a nominal fee. I understand and agree to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient signature: _____ Date: _____

Parent/Guardian Name: _____ Signature _____