Date:_____

New Patient Information

Name: _____

First Middle Last

Address: _____

Number Street City State Zip

Phone: _____ Cell: _____

DOB: _____ (circle) Sex: M F AGE: _____ Marital Status: S M D W

Number of Children: _____ I am currently _____ weeks pregnant.

Current Insurance: _____Email Address:_____

Occupation: _____ Employer: _____

Spouse Name: _____ Occupation:_____

I was referred by: _____

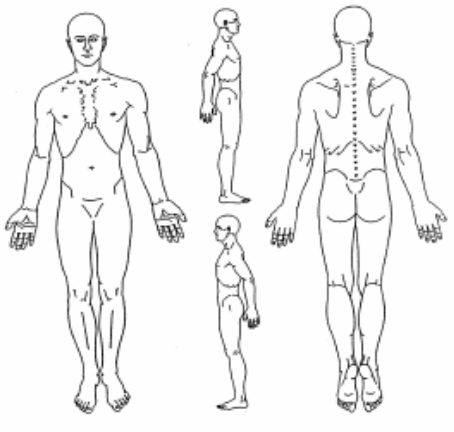
When and how did symptoms start: _____

Current Symptoms

	Pain	Stiffness	Tingling
Head	□	□	□
Neck	□	□	□
Mid- Back	□	□	□
Low Back	□	□	□
Shoulder	□	□	□
Hip	□	□	□
Knee	□	□	□

Pain level on a zero to ten scale.

1—2—3—4—5—6—7—8—9—10



Please circle areas where you feel pain.

Activities:

	Daily	2-3/ Week	Weekly	Monthly	Never
Exercise	▫	▫	▫	▫	▫
Smoke	▫	▫	▫	▫	▫
Drink Alcohol	▫	▫	▫	▫	▫

Medical History

I have had, or am currently being treated for:

Depression	▫	Arthritis	▫	Heart Disease	▫
Bipolar	▫	Asthma	▫	Parkinson's Disease	▫
Dementia	▫	Bleeding Disorder	▫	Kidney Disease	▫
Tuberculosis	▫	Diabetes	▫	Osteoporosis	▫
Cancer	▫	High Blood Pressure	▫	Migraine Headaches	▫

Other: _____

Surgeries:

	Date		Date		Date
Back:	_____	Hip:	_____	C-Section:	_____
Neck:	_____	Gall Bladder:	_____	Hysterectomy:	_____
Knee:	_____	Hernia:	_____	Appendix:	_____
Shoulder:	_____	Pacemaker:	_____	No Surgeries	▫
Other:	_____				

I currently take the following prescription or over the counter medications:

_____ _____ _____

_____ _____ _____

Chiropractor seen in past: _____

Family Medical History:

	Mother	Father	Brother	Sister
Diabetes	▫	▫	▫	▫
Cancer	▫	▫	▫	▫
Heart Disease	▫	▫	▫	▫
Kidney	▫	▫	▫	▫

I have been provided with the office Financial Policy and Assignment of Proceeds. I understand that while insurance carriers may be billed for my treatment that I remain responsible for all charges for my treatment.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care. I understand and agree that charges for any X-rays are for the examination, and that the x-ray films will remain property of this office, where being on file they may be seen anytime the patient is in our office. X-ray films removed from the office to be reviewed by other Doctors should be returned to our office.

Patient Signature: _____ Date: _____