Date: ___________________

New Patient Demographic Information

PATIENT INFORMATION

First Name:______________________ Middle Initial:____ Last Name:_________________________________

Street Address:____

City:_____________________________ State:__________ Zip Code:________________________

Birthdate:____________________ Social Security #:____________________ Sex (circle): M F

Email:___________________________________ Occupation:____________________________

Phone Number (Home/Cell):___________________________________

May we leave a message at: ☐ Home ☐ Cell

How did you hear about us? ☐ Google ☐ Family/Friend referral________________________________
Other: ☐ _____________________

Emergency Contact:_________________________________ Phone:__________________________

OTHER INFORMATION

Have you seen a chiropractor before? ☐ Yes ☐ No
If so, name of office and location:____

Have you had X-rays or other imaging taken recently? ☐ Yes ☐ No
If yes, date and location:____

Is this visit related to a work/auto injury, slips, falls, etc. ☐ Yes ☐ No
____

Have you ever been in a car accident? ☐ Yes ☐ No If so, when?__________________________

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

....

Patient or Guardian Signature:_____________________________________ Date:_______________________

REASON FOR TODAY'S VISIT

□ Emergency □ New Injury □ Old Injury □ Chronic Pain □ Wellness

Chief Complaint: ______________________________

Rate the intensity of your symptoms at this moment: 0 1 2 3 4 5 6 7 8 9 10

When did the complaint occur? _______________________________

Is your condition getting worse? □ Yes □ No □ Constant □ Comes and goes

Is your condition interfering with? □ Work □ Sleep □ Daily routine

If so, how? ____

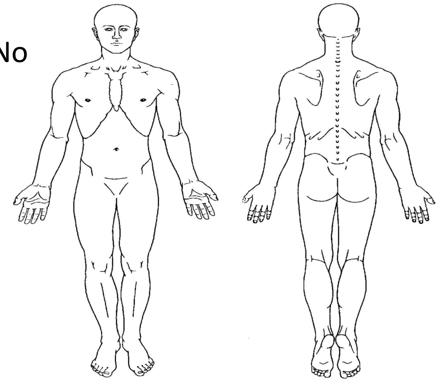
Has this happened in the past? □ Yes □ No

Explain: ____

USING THE ADJACENT CHART, PLEASE CIRCLE ALL AFFECTED AREAS

Have you been treated by another physician for this condition? □Yes □ No

If so, where? ____



Health History

Are you taking any of the following medications?

□ Pain Relievers (including aspirin) □ Muscle Relaxers □ Blood Thinners

□ Insulin □ Nerve Pills □ Tranquilizers

Other medications: ____

Do you have or have you had any of the following diseases, medical conditions, or procedures

Y N Alcoholism	Y N Difficulty Breathing	Y N High/Low Blood Pressure
Y N Anemia	Y N Drug Addiction	Y N HIV+/AIDS/ARC
Y N Arteriosclerosis	Y N Emphysema/COPD	Y N Kidney Problems
Y N Arthritis	Y N Epilepsy/Fainting/Seizures	Y N Low Back Problems
Y N Artificial Bones/Joints/Implants	Y N Fibromyalgia	Y N Migraines/Severe Headaches
Y N Artificial Valves	Y N Frequent Neck Pain	Y N Mitral Valve Prolapse
Y N Asthma	Y N Glaucoma	Y N Rheumatism/Rheumatic Fever
Y N Cancer	Y N Gout	Y N Shingles
Y N Chemotherapy	Y N Heart Attack/Stroke	Y N Sinus Problems
Y N Congenital Heart Defects	Y N Heart Murmurs	Y N Tuberculosis
Y N Depression/Psychosis	Y N Heart Surgery	Y N Ulcers/Colitis
Y N Diabetes	Y N Hepatitis	Y N Venereal Disease

Please list any surgeries with dates and/or any other serious medical conditions not listed above:____

Please list any allergies: ____

Family Health History: ____

Do you take vitamins/supplements? □ Yes □ No **Do you exercise?** □ Yes □ No **Do you smoke?** □ Yes □ No

FOR WOMEN: **Are you taking Birth Control?** □ Yes □ No **Are you Pregnant?** □ Yes □ No **Are you nursing** □ Yes □ No

I understand the above information and guarantee this form was completed correctly and to the best of my knowledge and understand it's my responsibility to inform this office of any changes to the information I have provided

Patient OR Guardian Signature: ____ **Date:** _____________________