chiropractic

Bringing Out The Best In You!

New Patient Welcome To Our Office

Date ______________________________

Name ______________________________ Preferred name ______________
Address ______________________________
City/State/Zip ______________________________
Phone #s (home) ______________ (cell) ______________
Email address ______________________________
SS # ______________ Birthdate ______________ Age ______
Occupation ______________ Employer ______________
Is it okay to contact you at work? ❍ no ❍ yes Work # ______________
Marital status ❍ single ❍ married ❍ separated ❍ divorced ❍ widowed
Spouse's name ______________ Phone #(s) ______________
Children's names and ages ______________________________
____
Do you have any pets? ❍ no ❍ yes If yes, please tell us what kind(s) ______________
____
Favorite hobbies or interests ______________________________
Emergency contact: Name ______________________________
Relationship ______________ Phone #(s) ______________

SAMPLE

What Brings You Here?

Have you ever had chiropractic care before? ❍ no ❍ yes
If yes, please tell us who ______________ Phone # ______________
Were you pleased with your care? ❍ no ❍ yes
How did you find out about our office? ______________________________
Is this appointment related to ❍ work ❍ sports ❍ auto
❍ personal injury ❍ other ______________
When did the incident occur? ______________________________
Attorney (if applicable) ______________ Phone # ______________
Are you receiving care from other health professionals? ❍ no ❍ yes
If yes, please name them and their specialty ______________________________
____
Please list any drugs or medications you are taking ______________________________
____
Please list any vitamins/herbs/homeopathics/other you are taking ______________
____
____
Are you pregnant? ❍ no ❍ yes If yes, what month? ______________

This form continues. Please turn the page.

Current Health

What are your pressing health concerns? ______________________________

____

____

____

____

For how long? ______________________________

Is it ❍ getting worse ❍ improving ❍ intermittent ❍ constant ❍ can't say

Where is the problem? Please use the illustrations and lines below to explain.

❍ Front ______________________________

____

____

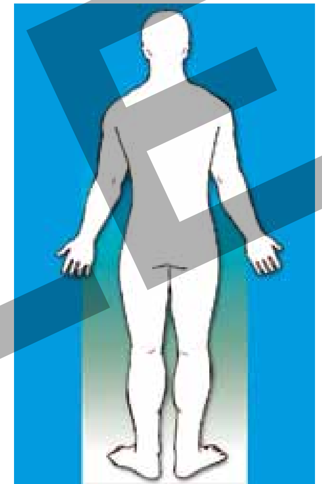
____

❍ Back ______________________________

____

____

____



Do you have ❍ pain ❍ numbness ❍ tingling ❍ aches

Is your pain ❍ sharp ❍ dull ❍ throbbing ❍ constant ❍ intermittent

Are your symptoms affected by ❍ sitting ❍ standing ❍ walking

❍ bending ❍ lying down ❍ weather ❍ other

Please explain ______________________________

____

Do you feel ❍ cramps ❍ burning ❍ stiffness ❍ swelling ❍ other

Please explain ______________________________

____

Do your symptoms interfere with ❍ work ❍ sleep ❍ day-to-day activities

❍ play ❍ other ______________________________

Please explain ______________________________

____

____

On a scale of 1-10 (1 least, 10 most), please rate:

The severity of your symptoms 1 2 3 4 5 6 7 8 9 10

SAMPLE

Health History

Do you have, or have you had, any of the following (please check ✓ all that apply)?

❍ pneumonia	❍ mumps	❍ influenza	❍ rheumatic fever	❍ smallpox
❍ pleurisy	❍ polio	❍ chickenpox	❍ thyroid disease	❍ diabetes
❍ epilepsy	❍ cancer	❍ depression	❍ whooping cough	❍ anemia
❍ eczema	❍ measles	❍ arthritis	❍ heart disease	❍ rashes
❍ colitis	❍ stroke	❍ allergies ____________		

If you have ever been diagnosed with another disease or condition, please describe____________________

____

Do you drink ❍ coffee ❍ tea ❍ alcohol

Do you use ❍ cigarettes ❍ recreational drugs ❍ artificial sweeteners ❍ sugar

Have you ever suffered from (please check ✓ all that apply)

❍ neck pain	❍ difficulty breathing	❍ discolored urine
❍ low back pain	❍ stuffy nose	❍ gas/bloating after meals
❍ headache	❍ fainting	❍ heartburn
❍ migraines	❍ weight loss	❍ irritable bowel
❍ arm pain/tingling	❍ poor appetite	❍ black or bloody stools
❍ shoulder pain	❍ excessive appetite	❍ constipation
❍ hand pain/tingling	❍ nervousness	❍ hemorrhoids
❍ leg pain/tingling	❍ confusion	❍ liver problems
❍ jaw pain	❍ depression	❍ paralysis
❍ chest pain	❍ dental problems	❍ numbness
❍ lung problems	❍ excessive thirst	❍ fatigue
❍ heart problems	❍ frequent nausea	❍ dizziness
❍ abnormal blood pressure	❍ prostate problem	❍ loss of sleep
❍ irregular heartbeat	❍ breast pain/lump	❍ difficulty hearing
❍ ankle swelling	❍ cramps	❍ ear pain
❍ cold extremities	❍ painful urination	❍ other ____________
❍ blurred vision	❍ bladder trouble	____________
❍ vision problems	❍ excessive urination	____________

If applicable, date of last menstrual period ____________________

Past injuries can affect present health (please check ✓ all that apply)

❍ falls/accidents	❍ head injuries	❍ fights	❍ surgery
❍ sports injuries	❍ broken bones	❍ dislocations	❍ other
❍ spinal tap	❍ knocked unconscious	❍ traction	____________
❍ use(d) a cane or walker	❍ extensive dental work	❍ dental applications	____________

If yes to any of the above, please describe ____________________

____

____

____

____

SAMPLE

What Do You Know About Chiropractic?

In your own words, what do chiropractors do? ______________________________

____

Do you know what a subluxation is? ❍ no ❍ yes

If yes, please describe ______________________________

____

Do any friends or relatives see chiropractors: ❍ no ❍ yes

If yes, do they use chiropractic for ❍ health maintenance/optimization ❍ health problems ❍ both

Are you seeking chiropractic for ❍ health maintenance/optimization ❍ health problems ❍ both

What would you like to gain from chiropractic care? ______________________________

____

____

Are there other health concerns or anything else you'd like us to know about you? ❍ no ❍ yes

If yes, please tell us ______________________________

____

____

____

____

____

____

____

SAMPLE

Financial Responsibility

Who is responsible for payment? ______________________________

How will you pay for your care? ❍ Cash ❍ Check ❍ Credit Card

Credit card # ______________________________ Exp. ______________

Insurance co. ______________________ Phone # ______________________

ID # ______________________ Group # ______________________

Subscribers's name ______________________ Phone # ______________________

Relation ______________________ Subscriber's employer ______________________

Subscribers's SS # ______________________ Subscriber's birthdate ______________________

The above is accurate to the best of my knowledge.

______________________________ (signature) ______________ (date)

I, parent/guardian, give permission for minor's care.

______________________________ (signature) ______________ (date)

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