

New Patient Information Form



Doctor

Date

Name		Preferred Name	
Address			
City, State		Zip Code	
Home Phone		Cell Phone	
Email		<input type="checkbox"/> I'd like to receive your email newsletter	
Social Security Number		Birth Date	Age
Occupation		Employer	
Is it okay to contact you at work?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Work Phone
Favorite Hobbies or Interests			
Marital Status	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Spouse's Name		Phone Number/s	
Children's Names and Ages			
Name of Emergency Contact			
Relationship		Phone Number/s	

Which doctor do you prefer? <input type="checkbox"/> Dr. Julie Restall, D.C. <input type="checkbox"/> Dr. Hollis Wilson, D.C. <input type="checkbox"/> No Preference		
How did you find out about our office?		
Have you ever had chiropractic care before?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, please tell us the doctor's name		
Were you pleased with your care?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you receiving care from other health care professionals?		<input type="checkbox"/> Yes <input type="checkbox"/> No
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		

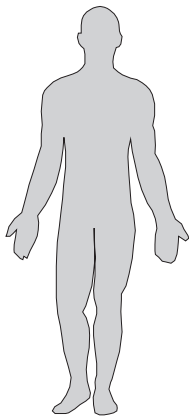
What Brings You Here?

Is this appointment related to Car Accident Workers Comp Other:

What is your primary reason for today's visit?

Is it Getting Worse Improving Intermittent Constant Can't Say

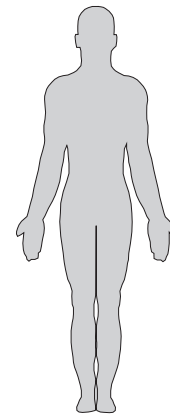
Where is the problem? Please use the illustrations and lines below to explain



Front

Front

Back



Back

When did the problem start?

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

Please explain

Do you feel Cramps Burning Swelling Stiffness
 Other:

Do your symptoms interfere with Work Sleep Day-to-day Activities
 Play Other:

Please explain

On a scale of 1 to 10 (1 least, 10 most) please rate the severity of your symptoms 1 2 3 4 5 6 7 8 9 10

Any additional complaints/concerns you would like addressed

Previous interventions, treatments, medications, surgery or care you've sought for your complaint

Health History

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

- | | | | | |
|------------------------------------|-------------------------------------|----------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Influenza | <input type="checkbox"/> Mumps | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Smallpox |
| <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Polio | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Depression | <input type="checkbox"/> Cancer | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Measles | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rashes |

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

Please check all items that are part of your lifestyle

- | | | | |
|---|-------------------------------|--|---------------------------|
| <input type="checkbox"/> Caffeine | Number of drinks per day: | <input type="checkbox"/> Alcohol | Number of drinks per day: |
| <input type="checkbox"/> Cigarettes | Number of cigarettes per day: | <input type="checkbox"/> Artificial Sweeteners | |
| <input type="checkbox"/> Recreational Drugs | If Yes, please explain: | | |

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

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Stuffy Nose | <input type="checkbox"/> Discolored Urine | <input type="checkbox"/> Low Back Pain |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Gas/Bloating After Meals | <input type="checkbox"/> Headache | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Migraines | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Arm/Back Tingling | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Shoulder Pain |
| <input type="checkbox"/> Excessive Appetite | <input type="checkbox"/> Black or Bloody Stools | <input type="checkbox"/> Hand Pain/Tingling | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Leg Pain/Tingling | <input type="checkbox"/> Confusion | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Excessive Thirst |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Frequent Nausea | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Abnormal Blood Pressure | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Numbness | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> Prostate Problem | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Breast Pain/Lump |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Cold Extremities | <input type="checkbox"/> Cramps | <input type="checkbox"/> Loss of Sleep |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Difficulty Hearing | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Bladder Trouble | <input type="checkbox"/> Ear Pain | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Excessive Urination |

If applicable, date of last menstrual period

Are you pregnant? Yes No If Yes, what month?

Past injuries can affect present health. Please check all that apply

- | | | | |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> Car Accidents | <input type="checkbox"/> Falls | <input type="checkbox"/> Sports Injuries | <input type="checkbox"/> Broken Bones |
| <input type="checkbox"/> Dislocations | <input type="checkbox"/> Spinal Tap | <input type="checkbox"/> Surgery | <input type="checkbox"/> Traction |
| <input type="checkbox"/> Use/d a Cane or Walker | <input type="checkbox"/> Extensive Dental Work | <input type="checkbox"/> Head Injuries/Knocked Unconscious | |

If Yes to any of the above, please describe and include dates

What Do You Know About Chiropractic?

In your own words, what do chiropractors do?

What would you like to gain from chiropractic care (what are goals for treatment)?

Financial Responsibility

Self paying patients are responsible for payment **AT TIME OF SERVICE.**

If I am using insurance for partial payment, I authorize the release of information and understand that I or my parent/guardian (if patient is under 18 years old) will be responsible for payment of any amounts that my insurance company

does not cover. This means that I will be responsible for my deductible, co-pay, co-insurance, or any services denied by my insurance for any reason.

I understand verification of benefits is not a guarantee of payment by my insurance company.

patient signature

date

signature of parent/guardian (if patient is under 18 years old)

date