NEW PATIENT QUESTIONNAIRE

Name ____ ◯ Female ◯ Male Date ___________________

What you prefer to be called ___________________________ Age _____ Date of Birth ____________________

Marital Status ◯ Single ◯ Married ◯ Widowed ◯ Divorced

Address ____ City _______________________

State ________ Zip Code ___________ Email ____

SS# ________________________ Cell Phone ________________________ Cell Provider __________________

◯ Check this box if you would like to OPT OUT of appointment reminder texts and emails.

◯ Check this box if you would like to OPT OUT of emails pertaining to office announcements (office closure, promotions, etc)

Employer _____________________________________ Occupation ____________________________________

Emergency Contact _________________________ Relation __________________ Phone __________________

How did you hear about our office? ____

When did your condition begin? ____

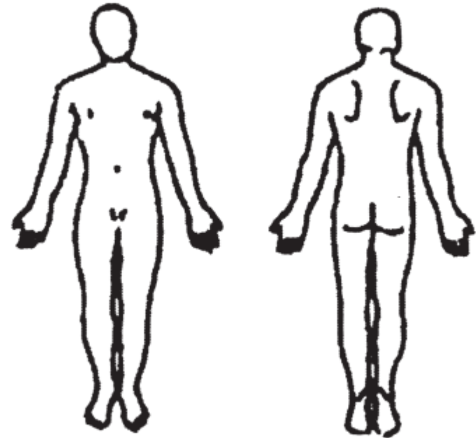
Other doctors seen for this condition? ____

Have you had the same or similar symptoms before? ◯ YES ◯ NO Date of prior condition ________________

List chief symptoms in order of severity:

(1) ____
(2) ____
(3) ____

Mark Areas of Pain on Figures Below



Have you had chiropractic care before? ◯ YES ◯ NO

Family Physician ___________________________________

Date of last physical exam ____________________________

May we forward our findings to your doctor? ◯ YES ◯ NO

Current Medications ________________________________

____

____

____

What vitamins, supplements, or herbs do you take? ____

Allergies (Medicine, Food, Environment) ____

Previous Surgeries ____

Do you have a PERSONAL history of: ◯ Cancer ◯ Diabetes ◯ Heart Disease ◯ Stroke

Other serious illness ____

Check all symptoms that apply to you:

◯ Headache ◯ Tingling/Numbness in arms/hands ◯ Chest Pain ◯ Unexplained weight loss

◯ Neck Pain/Stiffness ◯ Tingling/Numbness in legs/toes ◯ Knee Pain ◯ Fatigue

◯ Back Pain/Stiffness ◯ Loss of Balance/dizziness ◯ Hip Pain ◯ Night Sweats

◯ Shoulder Pain ◯ Shortness of Breath ◯ Fever ◯ Blood in Urine

◯ Other ____ ◯ Night Pain ◯ Pain unrelieved by rest

For Women

Are you pregnant? ◯ YES ◯ NO Due Date ____________________

Are you currently taking birth control? ◯ YES ◯ NO Number of Children ___________

HABITS	None	Light	Moderate	Heavy
Alcohol	◯	◯	◯	◯
Coffee/Soft Drinks	◯	◯	◯	◯
Tobacco/Drugs	◯	◯	◯	◯
Exercise	◯	◯	◯	◯
Sleep	◯	◯	◯	◯
Water	◯	◯	◯	◯

HEALTH INSURANCE

Policyholder Name __________________________________ Date of Birth ______________________

WORKERS COMPENSATION

Is your condition due to an EMPLOYMENT RELATED injury? ◯ YES ◯ NO Have you reported it? ◯ YES ◯ NO

Date of Accident ____________________________________

Supervisor ____ Supervisor # __________________________________

AUTO ACCIDENT

Is your condition related to an Automobile Accident? ◯ YES ◯ NO Date of injury ______________________

Auto Accident Insurance Name _______________________________ Claim # ____________________________

Adjuster Name ____ Phone # ___________________________

Attorney Name ____ Phone # ___________________________

INSURANCE INFORMATION, CONSENT OF PROFESSIONAL SERVICES, AND RELEASE OF INFORMATION

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on respect. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the doctors and their affiliated providers to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care, physical therapy, or any clinic services that they deem necessary in my case; I do hereby give my consent for the performance of conservative non-surgical treatment, including, but not limited to manipulation, physical therapy modalities, soft tissue massage and therapeutic exercises. I am aware there are possible risks and complications associated with these procedures, ranging from soreness to stroke. I understand there is no certainty that I will achieve benefits and acknowledge that no guarantee has been made regarding the outcome of these procedures. I am aware there are alternatives to these procedures including medication and/or surgery. In order to ensure that all my healthcare providers function as a team, I hereby grant the providers. I further authorize them to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the click or to the patient or a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical services companies, insurance companies, workers compensation carries, welfare funds, or the patient's employer. I understand that if an insurance company initially pays for my treatment and later requests reimbursement from this clinic for any reason, I will be responsible for payment of my entire outstanding balance.

We invite you to discuss any questions you might have with us. The best health services are based on a friendly mutually understood relationship.

Patient's or Guardian's Signature ____ Date ____________________

CONSENT TO TREAT A MINOR

I (we) being the parent, guardian, or custodian of the minor being ____________________________________, age ________, do hereby authorize, request and direct this clinic, its doctors and staff to perform examinations, diagnostics x-rays, laboratory tests, and any treatment that in their judgement, is deemed advisable or required.

It is the understanding of the undersigned that the physicians and their staff will have full authority from me as legal parent/guardian to continue with examinations, diagnostic tests, and treatments as will be needed while said minor shown above is under care in this office until legal age is attained.

As legal parent/guardian, I realize full responsibility for all charges and payments due.

Parent/Guardian or Custodian Signature _____________________________ Date Signed _____________