

New Patient Health Form



Patient Information

Date: _____
 SS/HIC/Patient ID # _____
 Patient Last Name _____
 First Name _____ MI _____
 Address _____
 City _____ State _____ Zip _____
 Email _____
 Sex M F Age _____
 Birthdate ____/____/____
 Married Widowed Single Minor
 Separated Divorced Partnered for _____ years
 Occupation _____
 Patient Employer/School _____
 Employer/School Address _____
 Employer/School Phone (____) _____ - _____
 Spouse's Name _____
 Birthdate ____/____/____
 Spouse's SS# _____ - _____ - _____
 Spouse's Employer _____
 Whom may we thank for referring you? _____

Insurance Information

Who is responsible for this account? _____
 Relationship to Patient _____
 Insurance Co _____
 Group # _____
 Is patient covered by additional insurance? YES NO
 Subscribers Name _____
 Birthdate ____/____/____ SS# _____ - _____ - _____
 Relationship to Patient _____
 Insurance Co _____
 Group # _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits. If any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions

The above named doctor may use my health care information and my discuss such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

 Signature of Patient/Parent, Guardian or Personal Representative

 Please Print Name

 Date

 Relationship to Patient

Phone Numbers

Home (____) _____ - _____
 Cell (____) _____ - _____
 Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____
 Relationship _____
 Home (____) _____ - _____
 Work (____) _____ - _____

Accident Information

Is condition due to an accident YES NO
 Date of accident _____
 Type of accident auto work home Other _____
 To whom have you made a report of your accident?
 auto insurance employer
 work comp Other _____
 Attorney name (if applicable) _____

Patient Condition

Reason for V/sit _____
 When did your symptoms appear? _____
 Is this condition getting progressively worse? YES NO Unknown

Mark an x on the picture where you continue to have pain, numbness or tingling

Rate severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

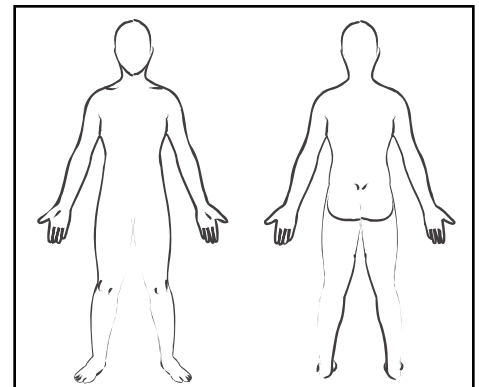
Type of Pain Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other _____

How often do you have this pain _____

Is it constant or does it come and go? _____

Does it interfere with your work sleep daily routine recreation

Activities or movements that are painful to perform sitting standing walking bending lying down



Health History

What treatment have you already received for your condition? Surgery Physical Therapy Chiropractic Services None Other

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last Physical Exam _____ Spinal X-ray _____ Blood Test _____ Spinal Exam _____

Chest X-Ray _____ Urine Test _____ Dental X-Ray _____ MRI, OT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

| | | | | | | | | |
|---------------------|------------------------------|-----------------------------|---------------------|------------------------------|-----------------------------|----------------------|------------------------------|-----------------------------|
| AIDS/HIV | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Glaucoma | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Pneumonia | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Alcoholism | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Goiter | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Polio | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Allergy Shots | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Gout | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Prostate Problem | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Anemia | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Heart Disease | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Prosthesis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Anorexia | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Hepatitis | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Psychiatric Care | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Appendicitis | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Herniated Disk | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Rheumatoid Arthritis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Arthritis | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Herpes | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Rheumatic Fever | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Asthma | <input type="checkbox"/> YES | <input type="checkbox"/> NO | High Cholesterol | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Scarlet Fever | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Bleeding Disorders | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Kidney Disease | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Stroke | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Breast Lump | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Liver Disease | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Suicide Attempt | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Bronchitis | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Measles | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Thyroid Problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Bulimia | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Migraines | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Tonsillitis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Cancer | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Miscarriage | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Tuberculosis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Cataracts | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Mononucleosis | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Tumors, Growths | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Chemical Dependency | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Multiple Sclerosis | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Typhoid Fever | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Chicken Pox | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Mumps | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Ulcers | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Diabetes | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Osteoporosis | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Vaginal Infections | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Emphysema | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Pacemaker | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Venereal Disease | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Epilepsy | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Parkinson's Disease | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Whooping Cough | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Fractures | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Pinched Nerves | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Other _____ | | |

| Exercise | Work Activity | Smoking | Habits |
|-----------------------------------|--------------------------------------|---|-----------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Sitting | <input type="checkbox"/> Alcohol | Packs per Day _____ |
| <input type="checkbox"/> Moderate | <input type="checkbox"/> Standing | <input type="checkbox"/> Coffee/Caffeine Drinks | Drinks per Week _____ |
| <input type="checkbox"/> Daily | <input type="checkbox"/> Light Labor | <input type="checkbox"/> High Stress Level | Cups per Day _____ |
| <input type="checkbox"/> Heavy | <input type="checkbox"/> Heavy Labor | | Reason _____ |

Are you pregnant? YES NO Date: _____

Injuries/Surgeries you have had

Falls _____

Head Injuries _____

Broken Bones _____

Dislocations _____

Surgeries _____

| Medications | Allergies | Vitamins/Herbs/Minerals |
|-----------------------------|-----------|-------------------------|
| | | |
| | | |
| | | |
| | | |
| Pharmacy _____ | | |
| Pharmacy Phone (____) _____ | | |