W E L C O M E

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PATIENT INFORMATION - PLEASE PRINT LEGIBLY Date _____ Sex: ❒ Female ❒ Male

Full Legal Name _____ Birthdate _____ Age _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Cell Network _____ Home Phone _____

☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Email Address _____

Nedd Chiropractic & Wellness Center does not share your personal contact information with any outside party. We use your phone and e-mail address for appointment reminders, our newsletter, and important notices. You may opt out of these services at any time.

Your Employer _____ Occupation _____ Work Phone _____

Spouse or Parents Name(s) _____ Number of Children _____ Grandchildren _____

Person to contact in case of emergency _____Phone _____

Whom may we thank for referring you to us? _____

Do you have insurance? ☐ Yes ☐ No Insurance Company Name _____

SYMPTOMS

Reason for visit _____ When did this condition start? _____

How is this condition changing? ☐ Getting Worse ☐ Getting Better ☐ Staying the Same

How would you describe the pain? ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numb ☐ Ache ☐ Shooting ☐ Sore

☐ Burning ☐ Tingling ☐ Cramping ☐ Tight ☐ Swollen ☐ Stabbing ☐ Electrical ☐ Other _____

Rate the severity of your pain. No Pain - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 - Severe Pain

What other doctors and treatment have you received for this condition? _____

_____

Women—Are you pregnant? ☐ Yes ☐ No If Yes, Guess Date? _____ Nursing? ☐ Yes ☐ No

Place of Delivery _____ Doctor or Midwife _____

HEALTH HISTORY

List any medications you are taking and for what conditions _____

_____

List any vitamins/supplements/herbs you are taking _____

_____

List any doctors you are currently seeing _____

Have you ever been under the care of a chiropractor before today? ☐ Yes, Dr. _____ ☐ No

Were you satisfied with him/her? ☐ Yes ☐ No for this reason _____

Allergies _____

(Continue on Next Page)

HEALTH HISTORY (CHECK ONLY THOSE WHICH APPLY. ALSO, WRITE IN **"C"** FOR CURRENT AND **"P"** FOR PAST.)

❑ AIDS/HIV	❑ Candida	❑ Head Trauma(s) #___	❑ Multiple Sclerosis	❑ Suicide Attempt
❑ Alcoholism	❑ Cataracts	❑ Heart Disease	❑ Mumps	❑ Thyroid Problems
❑ Allergy Shots	❑ Chemical Dependency	❑ Hepatitis	❑ Osteoporosis	❑ Tonsillitis
❑ Anemia	❑ Chicken Pox	❑ Hernia	❑ Pacemaker	❑ Tuberculosis
❑ Anorexia / Bulimia	❑ Chronic Fatigue	❑ Herniated Disc	❑ Parasites	❑ Tumors, Growths
❑ Appendicitis	❑ Depression	❑ High Blood Pressure	❑ Parkinson's Disease	❑ Ulcers
❑ Arthritis	❑ Diabetes	❑ High Cholesterol	❑ Pinched Nerves	❑ Vaginal Infections
❑ Asthma	❑ Emphysema	❑ Kidney Disease	❑ Pneumonia	❑ Varicose Veins
❑ Blood Clot	❑ Epilepsy	❑ Liver Disease	❑ Polio	❑ Venereal Disease
❑ Bleeding Disorders	❑ Fibromyalgia	❑ Measles	❑ Prostate Problems	❑ Whooping Cough
❑ Breast Lump	❑ Fractures	❑ Migraine Headaches	❑ Psychiatric Care	❑ _____
❑ Bronchitis	❑ Glaucoma	❑ Miscarriage	❑ Rheumatoid Arthritis	❑ _____
❑ Cancer	❑ Gout	❑ Mononucleosis	❑ Stroke	❑ _____

List any surgeries you have had and the approximate dates _____

_____ ☐ None

List any significant illnesses/hospitalizations you have had and the dates _____

_____ ☐ None

List any auto accidents you have had and the dates _____ ☐ None

List any traumas, significant injuries, concussions, unconsciousness, broken bones and dates _____

_____ ☐ None

List any vaccinations you have had in the past ten years and dates _____ ☐ None

_____ Were you vaccinated as a child? ☐ Yes ☐ No

FAMILY HISTORY

List family members that have died from anything other than old age, plus cause of death and age _____

_____

List any illnesses, physical and/or mental impairments any of your relatives suffer from _____

_____

DAILY HABITS

What type of exercise do you perform and how often? _____

Describe your daily work position/activities, for example: sitting, standing, light labor, heavy labor, computer work, driving _____

What is your typical diet? _____ Is it healthy and well-balanced? ☐ Yes ☐ No

How many hours of sleep to you get per night? _____ Do you have trouble falling asleep? ☐ Yes ☐ No

Do you have trouble staying asleep (wake up often)? ☐ Yes ☐ No How is your energy during the day? _____

Do you smoke? ☐ No ☐ Yes Amount per day? _____ How much liquor do you consume weekly? _____

How much coffee or caffeinated beverages do you consume on a daily basis?_____

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be personally responsible for payment of all services rendered on my behalf or my dependents.

X _____ _____

SIGNATURE OF PATIENT or GUARDIAN DATE