New Patient Form

Today's Date: _____
Legal Name: _____
Preferred name: _____
Date of birth: _____
Marital status (optional): _____
Street address: _____
City: _____ **State/ZIP:** _____
Primary phone: _____ **Alternate phone:** _____
Referred by: _____
Email: _____
Preferred contact: ☐ **Phone** ☐ **Text** ☐ **Email** **May we leave a message?** ☐ Yes ☐ No
Occupation: _____
Work Phone: _____

Responsible party/guardian, if different from patient: _____
Relationship: _____ **Phone:** _____

Member/Policy ID: _____ **Group number:** _____

Policyholder name: _____ **Date of birth:** _____
Relationship to patient: _____
Secondary insurance, if applicable: _____
Person responsible for payment: _____
Payment Method: ☐ **Cash** ☐ **Check** ☐ **Credit Card #**_____

☐ **I hereby authorize assignment of my insurance rights and benefits directly to the provide for services rendered.**

Primary Physician: _____
Have you had previous chiropractic care? _____
Main concern or goal for today: _____
_____
When did this begin? _____ **Pain level, if applicable (0–10):** _____
How did condition develop? _____
Date of onset_____ Have you had same or similar problems in the past? _____
Is the condition getting worse? _____
How long has it been since you felt good? _____
What aggravates condition? _____
Does anything offer relief?
How would you describe discomfort? ☐ **sharp** ☐ **dull** ☐ **achy** ☐ **throbbing**
What percentage does this condition bother you? ☐ **0%** ☐ **25%** ☐ **50%** ☐ **75%** ☐ **100%**

☐ **Heart Attack/Stroke**
☐ **Congenital Heart Defect**
☐ **Alcohol/Drug abuse**
☐ **HIV/Aids**
☐ **Frequent neck pain**
☐ **High/Low blood pressure**
☐ **Severe/Frequent headaches**
☐ **Fainting/Seizure/Epilepsy**
☐ **Diabetes**
☐ **Lower back pain**
☐ **Heart surgery**
☐ **Mitral Valve Prolapse**
☐ **Emphysema**
☐ **Shingles**
☐ **Thyroid disorder**

☐ **Alcohol/Drug abuse**
☐ **Glaucoma**
☐ **Psychiatric disorders**
☐ **kidney disease**
☐ **Sinus problems**
☐ **Asthma/COPD**
☐ **Artificial bones/joints**
☐ **Heart murmur**
☐ **Artificial valves**
☐ **Hepatitis**
☐ **Cancer**
☐ **Anemia**
☐ **Ulcers/Colitis**
☐ **Arthritis**
☐ **Chemotherapy**

Accidents (include dates):
_____
_____
Current medications, vitamins, and supplements: ☐ None
_____
_____
_____

Allergies: _____
Tobacco/nicotine: ☐ Never ☐ Former ☐ Current Amount: _____
Do you exercise regularly? How much/How long: _____
Are you wearing ☐ Heel lifts ☐ Sole lifts ☐ Inner solers ☐ Arch supports.
Age of mattress? _____
Women Only: Are you taking birth control? ☐ Yes ☐ No
Are you pregnant? ☐ Yes How long? _____ **☐ No**
Are you nursing? ☐ Yes ☐ No

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status. ‘

Patient/Legal representative signature: _____ **Date:** _____

Printed name: _____ **Relationship, if applicable:** _____