Welcome to Family Chiropractic Center of Nutley

Please tell us about yourself so that we may better serve you.

PATIENT HISTORY

(Please Print)

Date__/__/__

Full Name_____SS#____-___-_____

Name of Spouse or Guardian_____

Address_____City_____Zip_____

Marital Status (please circle one) S M D W Date of Birth___/___/___ Age___

Phone#, Home____-____-_____Work ____-____-_____Cell___-___-_____

Occupation_____E-Mail Address_____

Employer's Name & Address_____

Insurance Company_____Address_____

Name of Insured_____SS# of Insured_____-____-_____

Date of Birth of Insured ___/___/____ Doctor's name & #_____

_____

Who may we thank for referring you to our office?_____

Have you ever been treated by a Chiropractor before? __yes __no

If so, please explain: _____

_____

_____

_____

Is the reason for this visit (please circle) work auto trauma sports related?

When did this condition first occur? _____/___/_____

Please explain what happened _____

_____

_____

_____

_____

_____

Please describe the pain, if any, and its location_____

_____

_____

Is this condition getting worse? __ yes __no

Is this condition interfering with work or daily routine? __yes __ no

If so, please explain _____

_____

Have you ever had this or similar conditions in the past? __ yes __ no

If so, please explain _____

_____

Have you ever been treated by a M.D. for this or any other condition?__yes __no

If so, when? _____

(please continue on the back)

Have you ever been hospitalized for this or any other condition? __yes __ no
If so, please explain _____
_____
_____
_____

Are you allergic to any medications? __yes __ no
If so, please list _____
_____

Are you currently taking any medication __yes __no
If so, please list _____
_____
_____
_____
_____

Do you have any of the following?

__heart disease	__loss of memory	__neck pain
__diabetes	__sleeping problems	__stiff neck
__smoker	__tension	__stiff back
__birth control pill	__fainting spells	__hands cold
__visual disturbances	__dizziness	__numbness in fingers
__chest pain	__fatigue	__pins & needles in arms
__shortness of breath	__loss of balance	__head seems heavy
__buzz/ring in ears	__upset stomach	__depression
__irritability	__diarrhea	__loss of smell/taste
__face flushed	__constipation	__cold feet
__fever	__rapid weight change	__back pain
__cold sweats	__headaches	__numbness in toes
__nervousness	__light bothers eyes	__pins & needles in legs

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Family Chiropractic Center of Nutley may 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 Family Chiropractic Center of Nutley will be credited to my account upon receipt. 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 that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I authorize the staff of Family Chiropractic Center of Nutley to perform any necessary services during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

We invite you to discuss any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

Patient's Signature_____Date_____
Guardian's Signature_____Date_____