New Patient Case History

If we do not sincerely believe your condition will respond satisfactory, we will not accept your case. Thank You.

Name _____**DOB**_____**AGE**___**ID** _____

Address_____**City** El Paso **State** TX **Zip** _____

Home Phone ( )_____**Work** ( )_____**Email** _____

 # Of Children _____ **Ages** _____ **Marital Status M S D W**

Occupation _____ **TEL#**_____

Referred by _____**Emergency Contact** _____**Ph#** _____

Problem or major complaint _____

Health Information

Have you received previous chiropractic care? _____

Have you had this similar condition in the past? _____

What activities aggravate this condition? _____

Is this condition getting progressively worse? Yes □ No □ Constant □ Comes and Goes □

Is this condition interfering with your Work □ Sleep □ Daily Routine □ Other _____

How long has it been since you've felt well? _____

Have other Doctor's treated this condition? Yes □ No □ Who? _____

List surgical procedures and year _____

Drugs you currently take: Nerve Pills □ Pain Killers □ Muscle Relaxers □ Tranquilizers □

Insulin □ Contraceptive Pills □ Other _____

Age of Mattress_____ **Comfortable □ Uncomfortable □**

Do you wear? Heel Lifts □ Sole Lifts □ Inner Soles □ Arch Supports □ N/A □

Have you been involved in an auto accident or have had any other personal injuries?

Past year □ Past 5 yrs □ Over 5 yrs □ Never □

Describe the accident

_____

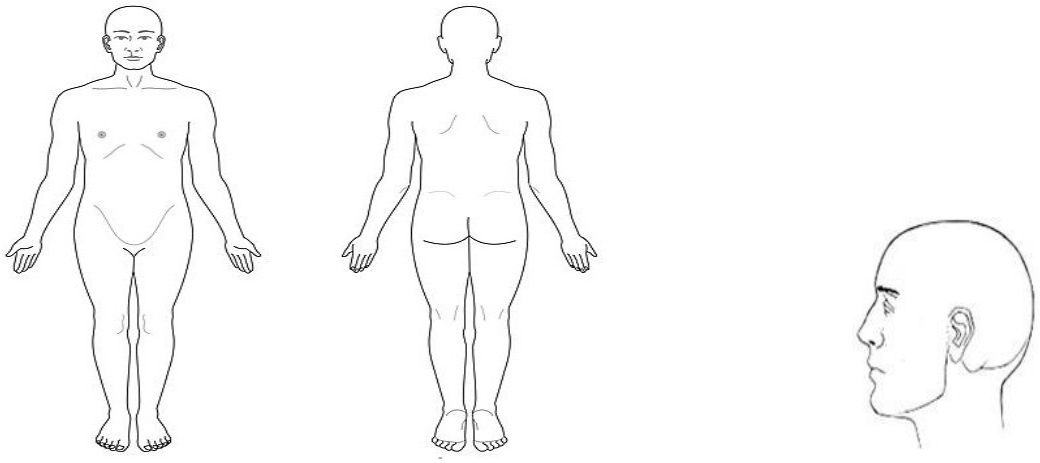
_____

Date of last physical examination_____ Have you ever suffered from the following conditions?

Dizziness □ Backaches □ Heart Trouble □ Diabetes □ Arthritis □ Headaches □

Asthma □ Neuritis □ Digestive Disorders □ Nervousness □ Sinus Trouble □ Neck Pain □

Please mark the areas of your pain on the figures below.



Family Health Information. (Many health problems are the result of hereditary spinal weaknesses, thus information about your family members will give us a better understanding of your total health condition).

Name	Relation	Past & Present Health Problems

Insurance Information

Is your condition due to an auto accident or to a job related injury? Yes □ No □ Are you insured? Yes □ No □

If yes, name of Insurance Company_____ Policy # _____

Are you covered by Medicare? Yes □ No □ If yes, Health Insurance # _____

I understand and agree that health and accident policies are an arrangement between and insurance carrier and myself. Furthermore, I understand that George's Chiropractic & Wellness Center 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 this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered will be 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 will be immediately due and payable.

Patient's Signature_____ Date_____

Guardian or Spouse's Signature_____ Date _____