HARRIS CHIROPRACTIC, INC.

NEW PATIENT HISTORY/REGISTRATION

Patient Name ______________________________

Address ______________________________

City ______________________________

State ____________ Zip ________

Responsible Name ______________________________
(The person who's name appears on the insurance card)

Referred To Office By ______________________________

Date ______________________________

DOB: ___/___/___ Male ☐ Female ☐

Home Ph ______________________________

Work Ph ______________________________

Cell Ph ______________________________

E-Mail Address ______________________________

General Practitioner ______________________________

Health Ins. ☐ Cash/Check/Charge ☐ BWC ☐ Auto Ins. ☐

Name of Ins. Co ______________________________

(Please attach insurance card for copying if applicable)

Please describe your complaint and mark the exact location on the diagram ______________________________

____

____

When did you first have these symptoms? ______________________________

What may have caused these symptoms (example: fall, accident, lifting, etc.) ______________________________

____

Is there anything that makes your condition worse? ______________________________

Is there anything that makes your condition better? ______________________________

Have you ever had these symptoms before? No ☐ Yes ☐

If yes, please explain (include previous treatment) ______________________________

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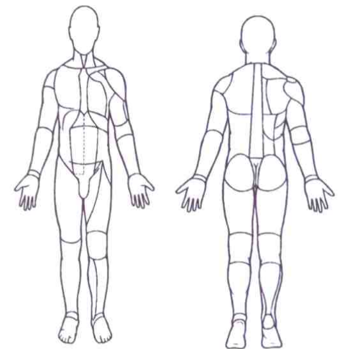

Any Chiropractic care in the past? No ☐ Yes ☐ Name ______________________________

Date ___/___/___

Have you ever had an automobile accident? No ☐ Yes ☐ Approximate Date (s)________________

Medical History (Please check any of the following relevant to your medical history)

☐ HIV Positive	☐ Tuberculosis	☐ High Blood Pressure	☐ Heart Trouble	☐ Diabetes
☐ Hepatitis	☐ German Measles	☐ Venereal Disease	☐ Multiple Sclerosis	☐ Convulsions
☐ Arthritis	☐ Rheumatism	☐ Chronic Fatigue Syndrome	☐ Concussion	☐ Epilepsy
☐ Asthma	☐ Digestive Disorders	☐ Sinus Trouble	☐ Cancer	☐ Anemia

List Allergies ______________________________

List Medications ______________________________

Briefly describe any surgeries, pacemakers, joint replacements, etc., if any ______________________________

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This certifies that the above information is correct to the best of my knowledge.

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whom ever he/she may designate as his/her assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, attorneys, or the patient's employer.

X ______________________________
Patient's Signature

X ______________________________
Parent or Guardian's Signature

Patient Health Goals

We all have desires regarding our health, and knowing these goals is very important to Dr. Harris. The more he can understand your desires for health, the better he can help you achieve optimal health and happiness. Understand that Dr. Harris has a near 100% success rate helping patients regain strength, vitality, fitness, and well being.

In order to achieve your health goals, tell us your key desires for health:

My primary desire is: ____

____

My secondary desire is: ____

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Many patients report with pain, dysfunction, degeneration, and weakness. To better understand how your condition is affecting you, please inform the doctor of your primary fears and concerns, as they relate to your health.

My primary concern or fear is: ____________________________________

____

My secondary concern or fear is: __________________________________

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