NEW PATIENT INFORMATION

Check Any Of The Following That May Apply To Your Family

Health Issues:

☐ Arthritis ☐ Stroke ☐ Bladder ☐ Gastrointestinal Issues
☐ Cancer ☐ Heart Disease ☐ Asthma ☐ Chronic Fatigue
☐ Diabetes ☐ Frequent Illnesses ☐ Allergies ☐ Genetic Disorders
☐ Neck/Back Pain ☐ Fibromyalgia ☐ Epilepsy ☐ Osteoporosis
☐ Obesity ☐ Lung Diseases ☐ High Blood Pressure
☐ Thyroid Disease ☐ Infections ☐ Low Blood Pressure
☐ Vertigo ☐ Scoliosis

☐ Multiple Sclerosis ☐ Other _____

Is There Other Family History We Should Know? _____

Check Any Problems That You May Have Had Within the Last Year

Muscles-Skeleton

☐ Low Back Pain
☐ Middle Back Pain
☐ Neck Pain
☐ Hips / Legs
☐ Joint Pain
☐ Shoulders/Arms
☐ Arthritis
☐ MuscleCramps/Spasm
☐ Fibromyalgia

Circulation-Breathing

☐ Chest Pain
☐ Difficulty Breathing
☐ High/ Low Blood Pressure
☐ Heart Rate Changes
☐ Poor Circulation
☐ Chronic Coughing/Wheezing
☐ Productive Cough
☐ Stroke

Eye-Ear-Nose-Throat

☐ Eyes / Vision
☐ Dental / TMJ
☐ Throat / Voice
☐ Ears / Hearing
☐ Sinus Pain / Drainage
☐ Taste Changes
☐ Swallowing Difficulty

Nerve System

☐ Headaches
☐ Nervousness
☐ Numbness/Tingling
☐ Weak Muscles
☐ Dizziness
☐ Shooting Pain
☐ Depression
☐ Fainting
☐ Seizures
☐ Cold Hands / Feet
☐ Anxiety
☐ Shaking / Tremors
☐ Chronic Fatigue

Digestion-Elimination

☐ Poor Appetite
☐ Excessive Thirst
☐ Nausea/Vomiting
☐ Diarrhea
☐ Constipation
☐ Hemorrhoids
☐ Weight Loss / Gain
☐ Heartburn/ Reflux
☐ Change In Stools
☐ Ulcers

Urinary-Genitals

☐ Pain With Urination
☐ Infrequent Urination
☐ Frequent Urination
☐ Weak Stream
☐ Bladder Control
☐ Genitals
☐ Difficult Urination
☐ Prostate

Female Only

☐ Menstrual Problems ☐ Breast Lumps/Pain
☐ Back Pain w/ Period ☐ Breast Implants
Possibly Pregnant YES NO

☐ Other Poblems _____

Please Read Sign

- I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS INCLUDING BUT NOT LIMITED TO BILLING SERVICES.
- I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE DOCTOR/ CLINIC FOR CHARGES SUBMITTED ON MY BEHALF.
- I AGREE TO PAY CHARGES NOT COVERED BY MY INSURANCE COMPANY (AND/ OR DEDUCTIBLES, CO-PAYMENTS OR COINSURANCE) DIRECTLY AND PROMPTLY TO THE DOCTOR/ CLINIC.

☐ **I HAVE RECEIVED THE CLINIC'S PRIVACY NOTICE. (PLEASE CHECK)**

Patient Signature _____ Date_____