New Patient Registration Form

Today's Date	

Please Print

PATIENT INFORMATION

Full Legal Name (First) (Middle) (Last)				Name Normally Used (Nickname)	
Address	City	State	Zip		
Cell Phone	Home Phone	Work Phone	E-Mail		
Marital Status M S D W	Date of Birth	Age	Sex M F	Have you seen a chiropractor In the past? Yes No	How long ago?
Employer Name	Position	Type of work performed	How Did You Hear About Us?		
List anyone you authorize this office to share your medical information with (name and relationship to you)					
Permitted / Preferred Contact Method(s) (circle all that apply) home phone cell phone work phone e-mail In the future we will be offering appointment reminders, would you prefer: Voice Text None				Ok to leave message on answering machine / voicemail? Yes___ No___	

SPOUSE'S INFORMATION

Full Legal Name (First) (Middle) (Last)			Home Phone
Occupation	Employer name	Work phone	Cell Phone

Person to Notify in Case of Emergency	Relationship	Home Phone	Cell Phone

INFORMATION FOR THE PATIENT

1. In order to make chiropractic care more affordable to everyone; we do not accept or file insurance claims. We can provide a super bill at your request so you can submit to your insurance carrier. There is no guarantee that your carrier will reimburse you for the services that you receive in our office.

2. Patients who carry standard health insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. All patients with standard health care insurance are expected to make payment as services are rendered, regardless of pending insurance, litigation, etc

Patient/ Guarantor Signature:

______________________________ Date:______________

Guardian Signature if Patient is Minor :

______________________________ Date:______________

Name: ______________________ Date: ______________________

Complaint #1 ______________________

What caused it? ☐ Auto accident ☐ Work injury ☐ Unknown ☐ Other ______________

When did it start? Day(s)______ Months________Years______ Exactly______________

Have you had similar symptoms before? ☐Yes ☐No If yes, when? ______________

Does it radiate into Arms or Legs? ☐ Yes ☐No ☐If yes, describe: ______________

Describe frequency of symtoms: ☐ Constant ☐ Comes and Goes

Describe the symptoms: ☐Dull ☐Sharp/stabbing ☐Burning ☐Tingling ☐Numb ☐Other__________

Are symptoms: ☐ Getting Better ☐ Getting Worse ☐ About the Same

Is it Worse ("W") Improved ("I") or Unchanged ("U") in the?

Morning______ Afternoon______ Evenings______ Night______ Sleeping______

Is it Worse ("W") Improved ("I") or Unchanged ("U") during the following activities?

Sitting______ Standing______ Laying down______ Activity______ Inactivity______ Bending______ Twisting______

Complaint #2 ______________________

What caused it? ☐ Auto accident ☐ Work injury ☐ Unknown ☐ Other ______________

When did it start? Day(s)______ Months________Years______ Exactly______________

Have you had similar symptoms before? ☐Yes ☐No If yes, when? ______________

Does it radiate into Arms or Legs? ☐ Yes ☐No ☐If yes, describe: ______________

Describe frequency of symtoms: ☐ Constant ☐ Comes and Goes

Describe the symptoms: ☐Dull ☐Sharp/stabbing ☐Burning ☐Tingling ☐Numb ☐Other__________

Are symptoms: ☐ Getting Better ☐ Getting Worse ☐ About the Same

Is it Worse ("W") Improved ("I") or Unchanged ("U") in the?

Morning______ Afternoon______ Evenings______ Night______ Sleeping______

Is it Worse ("W") Improved ("I") or Unchanged ("U") during the following activities?

Sitting______ Standing______ Laying down______ Activity______ Inactivity______ Bending______ Twisting______

Please mark the intensity of your complaints today.

0 = NONE 10 = INTENSE / SEVERE

Example: Neck

0 1 2 3 4 (5) 6 7 8 9 10

1. ______________________

0 1 2 3 4 5 6 7 8 9 10

2. ______________________

0 1 2 3 4 5 6 7 8 9 10

3. ______________________

0 1 2 3 4 5 6 7 8 9 10

4. ______________________

0 1 2 3 4 5 6 7 8 9 10

Indicate the location and type of your pain

Keys

000000	Pins & Needles
XXXXX	Burning
////////	Stabbing
=====	Numbness
+++++	Aching

Right Left Left Right

Name:______________________

Please mark X for present condition, O for past conditions:

___ Fractured Bones ___Auto Accidents ___ 0-1 yrs ___ 1-5 yrs ___ more than 5 yrs	___ Sinus Problems ___ Eating Disorders ___ Trouble Sleeping ___ Trouble Concentrating	___ Dizziness ___ Fainting ___ Loss of Balance	___ Colon Trouble ___ Liver Trouble ___ Gallbladder Trouble ___ Kidney Trouble
___ Accidents/Falls ___ Arthritis ___Diabetes ___Swollen/ Painful Joints ___ Osteoporosis	___ Learning Disability ___ Mood Changes ___ Headache ___ Numbness/ Tingling ___ Pain in arms/ hand/ fingers R L	___ Distressed Vision ___ Ringing in Ears ___ Hearing Loss ___ Ear Infections	___Hemorrhoids ___ Prostate Problems ___ Impotence ___ Ulcers
___ Convulsions/ Epilepsy ___ Skin Problems ___ Cancer ___ Frequent Colds/ Flu	___ Jaw Pain/ TMJ R L ___ Head/ Shoulders feel tired ___ Difficulty in Excessive (standing, walking, bending, riding, lifting, household duties) ___ Foot Troubles	___ Stroke ___ High Blood Pressure ___ Low Blood Pressure ___ Chest Pain ___ Heart Problems	___Menstrual Problems/PMS ___ Menopausal Problems
___ Depressed ___ Anemia ___ Back Curvature ___ Tremors ___ Allergies	___ Back Pain/ Stiffness ___ Numbness, Tingling or Pain in buttocks, thighs, legs, feet or toes ___ Hip Pain	___ Asthma ___Lung Problems ___ Difficulty Breathing ___Heartburn ___ Digestive Problems ___ Diarrhea/ Constipation	___ Pregnant (now) ___ Bed Wetting ___ AIDS/ HIV

Are you on any medication(s):______________________________________

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List Surgeries if any:______________________________________

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