NEW PATIENT FORM

Name _____ **Age** _____ **Employer** _____

Address _____ **Address** _____

City _____ **State** _____ **Zip** _____ **City** _____ **State** _____ **Zip** _____

Date of Birth _____ **SS#** _____ **Occupation** _____

Home Phone # _____ **Business Phone #** _____ **Cellular Phone #** _____

E-Mail Address _____

Primary Physician _____ **Address and/or Phone #** _____

Who is responsible for your bill? You and ☐ **Medical Insurance** ☐ **Medicare** ☐ **Auto Insurance** ☐ **Spouse**

In case of emergency, contact _____ **Phone #**_____ **Second #** _____

Name of your primary insurance company _____

Name of your secondary insurance company _____

Referred by _____

Gender: ☐ **Male** ☐ **Female** **Marital Status:** ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Separated** ☐ **Widowed**

YOUR MAIN PROBLEM

WHAT ONE HEALTH PROBLEM BOTHERS YOU THE MOST? (CHOOSE 1)

☐ Headache ☐ Neck Pain ☐ Arm ☐ Ankle ☐ Numbness/Tingling
☐ Low Back Pain ☐ Hand ☐ Leg ☐ Stiffness ☐ Gastrointestinal Problems
☐ Shoulder ☐ Knee ☐ Hip ☐ Sinus/Allergy ☐ Recurrent/Frequent Illness
☐ Mid-Back Pain ☐ Elbow ☐ Foot ☐ Buttocks ☐ Joint Pain/Dysfunction
☐ Forearm ☐ Wrist/Carpal Tunnel
☐ Other: _____

Today's Date		

SEVERITY
☐ Very Severe
☐ Severe
☐ Moderate
☐ Mild

FREQUENCY
☐ Constant
☐ Frequent
☐ Occasional

LOCATION
☐ Left Side
☐ Right Side
☐ Both Sides

DURATION
☐ Less than 3 weeks
☐ 3 weeks to 3 months
☐ Longer than 3 months

Patients ID								
			–					

Describe the problem in detail: _____

DESCRIPTION OF PROBLEM AT ITS WORST? (choose all that apply)
☐ Can't stand it ☐ Bothers me often ☐ Puts me in bed
☐ Annoying ☐ Can't sleep ☐ Makes it hard to do things
☐ Other: _____

INTERFERENCE WITH WORK AND/OR LIFESTYLE? (choose all that apply)
☐ Can't work ☐ Can't Concentrate
☐ Work is difficult because of problem ☐ Can't do certain exercises
☐ Can't do normal recreational activities ☐ Hard to get around
☐ Can't do simple activities of daily living ☐ Does not affect work/lifestyle

IF THIS PROBLEM IS NOT ACCIDENT RELATED, WHAT BROUGHT IT ON?
☐ Don't know ☐ Nothing really, it just started
☐ Stress ☐ Over-doing it
☐ Other: _____

IF THIS PROBLEM WAS CAUSED BY AN ACCIDENT WITHIN THE LAST 6 MONTHS, WAS THE ACCIDENT:
☐ Automobile related ☐ Work related ☐ Recreational
☐ Other: _____

OTHER HEALTH PROBLEMS (Mark and of the following you have currently)

GASTRO-INTESTINAL
☐ Poor/Excessive appetite
☐ Excessive thirst
☐ Frequent nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Hemorrhoids
☐ Liver problems
☐ Gall bladder problems
☐ Weight trouble
☐ Abdominal cramps
☐ Gas/bloating after meals
☐ Heartburn
☐ Black/bloody stool
☐ Colon Problems
☐ Indigestion

MUSCULO SKELETAL
☐ Low back pain
☐ Pain between shoulders
☐ Neck pain
☐ Arm pain
☐ Joint pain/Stiffness
☐ Walking problems
☐ Difficulty chewing
☐ Clicking Jaw
☐ General stiffness
☐ Leg Pain
☐ Mid Back pain
☐ Hand pain
☐ Foot Pain

EENT
☐ Vision problems
☐ Dental problems
☐ Sore throat
☐ Earaches
☐ Hearing difficulty
☐ Stuffed Nose

MALE-FEMALE
☐ Menstrual irregularity
☐ Menstrual cramping
☐ Vaginal pain/Infections
☐ Breast pain/Lumps
☐ Prostate problems
☐ Sexual dysfunction

GENERAL
☐ Fatigue
☐ Allergies
☐ Loss of sleep
☐ Fever
☐ Headaches
☐ HIV/AIDS
☐ Frequent illness
☐ Diabetes

NERVOUS SYSEM
☐ Nervousness
☐ Numbness
☐ Paralysis
☐ Dizziness
☐ Forgetfulness
☐ Confusion
☐ Fainting
☐ Convulsions
☐ Cold extremities
☐ Tingling extremities
☐ Depression
☐ Weakness
☐ Stress
☐ Family problems
☐ Job Related problems
☐ Fear
☐ Anger/Hostility
☐ Anxiety

CARDIOVASCULAR SYSTEM
☐ Chest pain
☐ Short breath
☐ Blood pressure problems
☐ Irregular heartbeat
☐ Heart problems
☐ Lung problems/Congestion
☐ Varicose veins
☐ Ankle swelling
☐ Stroke

GENITO-URINARY
☐ Bladder trouble
☐ Painful/Excessive urination
☐ Discolored urine
☐ Discharge
☐ Itching
☐ Burning

☐ Other Problems: _____

PAST HEALTH PROBLEMS (Mark any of the following that you have had in the past)

- ☐ Alcoholism
- ☐ Allergy
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Broken bone
- ☐ Cancer
- ☐ **Known blood clot**
- ☐ Cardiovascular disease
- ☐ Chorea
- ☐ Cold Sores
- ☐ **Diabetes**
- ☐ Disc problems
- ☐ Diphtheria
- ☐ **Eczema**
- ☐ Epilepsy
- ☐ **Stent within 6 months**
- ☐ HIV
- ☐ Goiter/Thyroid
- ☐ Gout
- ☐ Heart disease
- ☐ Influenza
- ☐ Low back pain
- ☐ Malaria
- ☐ Mental Illness
- ☐ **Disease/bacterial infection**
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problems
- ☐ Other _____
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Whooping cough

SOCIAL HISTORY (Mark any habits that currently apply)

SMOKING
- ☐ Never
- ☐ Occasionally
- ☐ Moderately
- ☐ Excessively

ALCOHOL
- ☐ Never
- ☐ Occasionally
- ☐ Moderately
- ☐ Excessively

RECREATIONAL DRUGS
- ☐ Never
- ☐ Occasionally
- ☐ Moderately
- ☐ Excessively

EXERCISE
- ☐ Never
- ☐ Occasionally
- ☐ Moderately
- ☐ Excessively

HIGH RISK SPORTS
- ☐ Never
- ☐ Occasionally
- ☐ Moderately
- ☐ Excessively

HEALTH HISTORY (Mark relatives that have had the following conditions)

CANCER
- ☐ Father
- ☐ Mother
- ☐ Brothers
- ☐ Sisters
- ☐ Children

DIABETES
- ☐ Father
- ☐ Mother
- ☐ Brothers
- ☐ Sisters
- ☐ Children

HEART PROB.
- ☐ Father
- ☐ Mother
- ☐ Brothers
- ☐ Sisters
- ☐ Children

HIGH BLOOD PRES.
- ☐ Father
- ☐ Mother
- ☐ Brothers
- ☐ Sisters
- ☐ Children

NECK PROBLEMS
- ☐ Father
- ☐ Mother
- ☐ Brothers
- ☐ Sisters
- ☐ Children

MULTIPLE SCLEROSIS
- ☐ Father
- ☐ Mother
- ☐ Brothers
- ☐ Sisters
- ☐ Children

PINCHED NERV.
- ☐ Father
- ☐ Mother
- ☐ Brothers
- ☐ Sisters
- ☐ Children

PSYCH
- ☐ Father
- ☐ Mother
- ☐ Brothers
- ☐ Sisters
- ☐ Children

BACK PROB.
- ☐ Father
- ☐ Mother
- ☐ Brothers
- ☐ Sisters
- ☐ Children

JOINT PROB.
- ☐ Father
- ☐ Mother
- ☐ Brothers
- ☐ Sisters
- ☐ Children

ARTHRITIS
- ☐ Father
- ☐ Mother
- ☐ Brothers
- ☐ Sisters
- ☐ Children

ALLERGIES
- ☐ Father
- ☐ Mother
- ☐ Brothers
- ☐ Sisters
- ☐ Children

SCOLIOSIS
- ☐ Father
- ☐ Mother
- ☐ Brothers
- ☐ Sisters
- ☐ Children

HEADACHES
- ☐ Father
- ☐ Mother
- ☐ Brothers
- ☐ Sisters
- ☐ Children

STROKE
- ☐ Father
- ☐ Mother
- ☐ Brothers
- ☐ Sisters
- ☐ Children

WHAT TYPE OF MEDICATION DO YOU CURRENTLY TAKE?

☐ Pain medication ☐ Anti-Inflammatory Medication ☐ Muscle Relaxers ☐ Anti-Depression/Tranquilizers

List all medications you currently take: _____

Ladies: Any possibility of pregnancy? YES NO (If you become pregnant, please let us know.)

Do you currently have a Pacemaker/Defibrillator? YES NO

Surgeries: _____

_____

Location of any scars: _____

_____

Falls/Accidents: _____

_____

I authorize the doctors and staff of this clinic to examine and treat me as they find necessary. I further authorize clinic personnel to release information regarding my case to insurance companies or other professionals if necessary. I certify that all the information I have given true and correct. I also certify that I am here for the sole purpose of getting better and no other reason.

Patient Signature: _____ **Date:** _____

AUTHORIZATION AND ASSIGNMENT (Insured Patients)

I authorize the direct payment of this clinic of any sum I owe, by any insurance company or third party obligated to reimburse me for charges for your services. However, it is understood that after reasonable efforts have been made to collect the sums due from my insurance company, whatever amounts not collected from insurance proceeds become due and payable by me. The authorization and assignment is irrevocable until bill is fully paid.

Patient Signature: _____ **Date:** _____