

New Patient Information

****NOTE: If this is a Workers' Compensation or Auto Accident Case, please tell Receptionist NOW before you start this form.****

Patient Data

First Name _____ Last Name _____ Email* _____

* Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements and promotions.

Mailing Address

Address _____ City _____ State _____ Zip _____

Telephone (Work) _____ (Cell) _____ **REFERRED BY** _____

Age _____ Birth Date _____ Social Security # _____ Number of Children _____

Occupation _____ Employer _____

Marital Status _____ Spouse's Name _____

Emergency Contact _____ Phone _____

Current Complaints

Nature of Complaint **Automobile*** **Work** **Other**

List of complaints: _____

Date of injury _____ Date symptoms appeared _____

Have you ever had same condition? **No** **Yes** If yes, when? _____

List of other practitioners seen for this injury/condition _____

What activities aggravate symptoms _____

Are your symptoms worse during certain times of the day? **No** **Yes** Explain _____

Insurance information

Name of party responsible for payment _____ Phone _____

Do you have health insurance? **No** **Yes** Name of company _____

Medicare **No** **Yes** Medicare Supplement **No** **Yes**

Medicare Advantage Plan **No** **Yes**

Signatures

Name of the insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility.

I authorize Family Life Chiropractic to render chiropractic care and treatments. If applicable, I give them permission to bill my insurance company and accept payment on my behalf. I agree to be responsible for payment.

Signature _____ Date _____

I hereby represent the above named patient as a MINOR and give authorization for full chiropractic care and treatments. I agree to be responsible for payment.

Signature _____ Relationship _____ Date _____

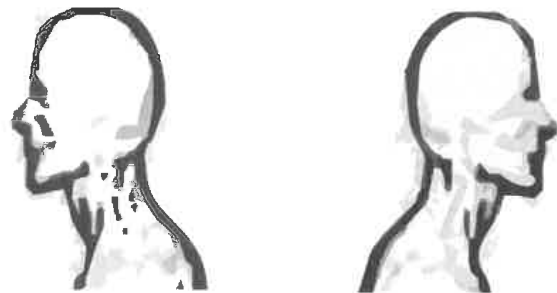
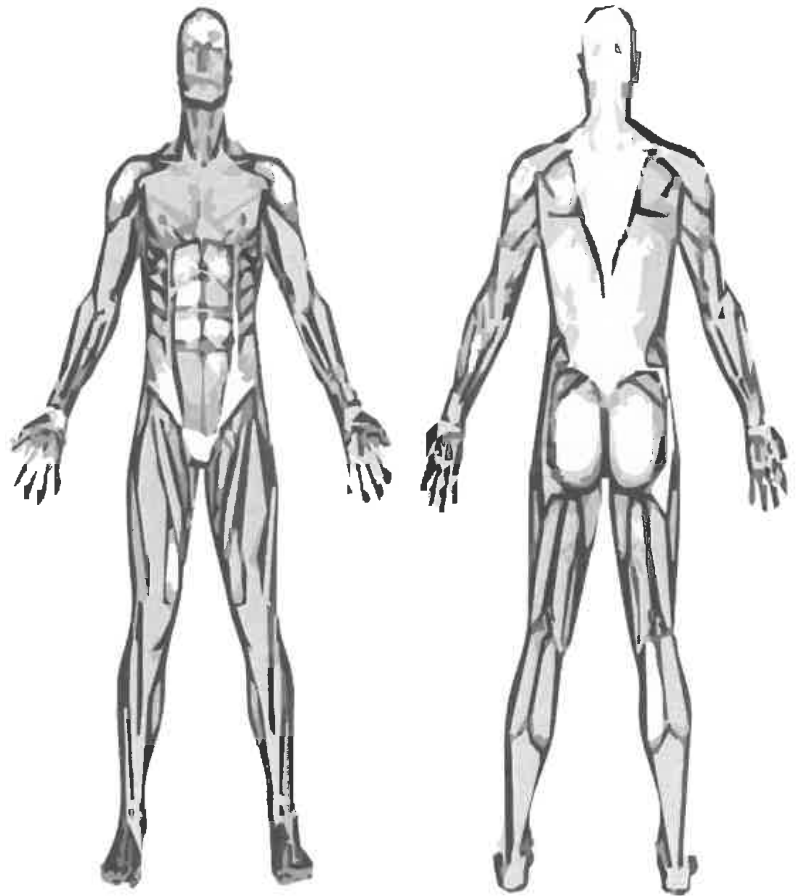
Have you ever suffered from:

Interferes with daily life?

- | | | |
|---|-----------------------------|------------------------------|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Chest Pain/Conditions | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Cold Extremities | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Cramps | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Depression | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Digestion Problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Ears Ring | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Excessive Menstruation | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Eye Pain or Difficulties | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Irregular Cycle | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Loss of memory | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Loss of smell | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Loss of taste | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Lumps In Breast | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Neck Pain or Stiffness | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Polio | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Poor Posture | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Prostate Trouble | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Sinus Infection | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Sleep problems or insomnia | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Spinal Curvatures | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Swelling of ankles | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Swollen Joints | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Thyroid Condition | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Other _____ | | |

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

- | | |
|---------------------|---------------------------|
| A = Ache | P = Pins & Needles |
| B = Burning | S = Stabbing |
| N = Numbness | O = Other |



Medical History

Have you been treated for any condition in the last year? No Yes

If yes, please describe _____

Date of last physical exam _____ Is there a chance that you are pregnant? No Yes

Have you had X-rays taken? No Yes If yes, where? _____

What medications are you taking and for what conditions (Please list dosage and amounts, etc.) _____

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency.) _____

Have you ever:	No	Yes	Briefly Explain
Had broken bones?	<input type="radio"/>	<input type="radio"/>	
Been hospitalized?	<input type="radio"/>	<input type="radio"/>	
Been in an auto accident?	<input type="radio"/>	<input type="radio"/>	
Had Sprains/Strains?	<input type="radio"/>	<input type="radio"/>	
Been struck unconscious?	<input type="radio"/>	<input type="radio"/>	
Had surgery?	<input type="radio"/>	<input type="radio"/>	
Have you ever been under chiropractic care?	<input type="radio"/>	<input type="radio"/>	

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Habits	None	Light	Moderate	Heavy
Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coffee	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tobacco	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Appetite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Soft Drinks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Water	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Salty Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sugary Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Artificial Sweeteners	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>