COMMUNITY CHIROPRACTIC CARE

NEW PATIENT INFORMATION

THANK YOU FOR CONSIDERING OUR OFFICE FOR YOUR HEALTH CARE NEEDS

Your Name:_____ Date:_____

Home Phone:_____ Alt. Phone:_____ Birth Date:_____

Address:_____ City:_____ State:_____ Zip_____

Marital Status: S M D W Sep Social Security #: _____

Employer: _____ Occupation: _____

WHO TO CONTACT IN CASE OF AN EMERGENCY

Name:_____ Relationship:_____ Phone: _____

Payment will be made by: ☐ Cash/Check/Charge ☐ Health Insurance
☐ Worker's Compensation ☐ Personal Injury

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

If you have no symptoms or complaints, and are here for wellness services, please check here (____) and skip to the next page, *Past Medical History*. Otherwise, continue with the question below.

What is the major complaint?_____

_____

If known, what caused this condition?_____

_____

When did the symptoms first appear?_____

Have you ever received any treatment for this condition?_____

If YES, Where? When? What were your results?_____

_____

Have you ever had the same or similar problem?_____ If YES, please explain:_____

_____

Is the problem getting better, worse, or staying the same?_____

Is your condition affecting your life?

a. Personal Life? ☐ Yes ☐ No How?_____

b. Work Life? ☐ Yes ☐ No How?_____

c. Activities? ☐ Yes ☐ No Which activities?_____

IF DUE TO AN ACCIDENTAL INJURY, PLEASE COMPLETE BELOW

Date of Accident:_____ Location:_____

Cause: ☐ Auto Injury ☐ Job Injury ☐ Slip & Fall ☐ Other:_____

If Auto, were you: ☐ Driver ☐ Passenger ☐ Pedestrian

If Auto, where was car struck::_____

Please describe how the injury or accident occurred: _____

_____

If job related, was accident reported? ☐ Yes ☐ No Date Reported:_____

Have you lost time from work? ☐ Yes ☐ No Dates of Loss:_____

Do you have an attorney? ☐ Yes ☐ No Attorney's Name:_____

I authorize Community Chiropractic Care to furnish my insurance company with any information needed regarding my condition. I further authorize and direct my insurance carrier to pay all benefits which may be due me, according to my policy, directly to Community Chiropractic Care to be applied to my account.

Signature:_____ **Date:**_____

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first to address the issues that brought you to this office, and second, to offer you the opportunity of improved health, and preventative and wellness services in the future. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health.

HEALTH HISTORY

Have you ever seen a Chiropractor before? ☐ Yes ☐ No Last seen:_____

Other Doctors, PCP, Specialists:_____

_____

Date of Last: Physical Exam_____ Spinal X-ray_____ Blood Test_____ Spinal Exam_____ Chest X-ray_____

Urine Test_____ Dental X-ray_____ MRI, CT-Scan, Bone Scan_____

Please ☑ symptoms you currently have:

☐ Balance impairment	☐ Headaches	☐ Loss of concentration	☐ Restless sleep	☐ Twitching muscles
☐ Burning/Dry eyes	☐ Inc. urinary freq.	☐ Loss of memory	☐ Ringing ears	☐ Vertigo
☐ Depression/anxiety	☐ Lightheadedness	☐ Nausea	☐ Tremors	☐ Visual changes

Please ☑ conditions or symptoms you currently have or have had in the past:

☐ AIDS/HIV	☐ Cataracts	☐ Hernia	☐ Parkinson's	☐ Ulcers
☐ Allergies	☐ Diabetes	☐ Herniated disk	☐ Polio	☐ Urinary tract infect.
☐ Anemia	☐ Diarrhea/constipation	☐ High blood pressure	☐ Prosthesis	☐ Varicose veins
☐ Appendicitis	☐ Difficulty swallowing	☐ High cholesterol	☐ Rheumatoid arthritis	☐ Weight changes
☐ Arthritis	☐ Digestive problems	☐ Jaw pain/TMJ	☐ Seizures	☐ Other:
☐ Asthma	☐ Gallbladder disease	☐ Kidney disease	☐ Sinus problems	_____
☐ Blood clots	☐ Glaucoma	☐ Liver disease	☐ Skin conditions	_____
☐ Breast lump	☐ Hearing loss	☐ Menstrual problems	☐ Stroke	_____
☐ Breathing problem	☐ Heartburn/indigestion	☐ Multiple sclerosis	☐ Thyroid problems	_____
☐ Bronchitis	☐ Heart disease	☐ Osteoporosis	☐ Tuberculosis	_____
☐ Cancer	☐ Hepatitis	☐ Palpitations	☐ Tumors/growths	_____

EXERCISE

☐ None ☐ Rare
☐ Occ. ☐ Freq.

WORK ACTIVITY

☐ Sitting ☐ Light labor
☐ Standing ☐ Heavy labor

LIFESTYLE

☐ Smoking: Packs/Day ____ ☐ Coffee/Caffeine: Cups/Day____
☐ Alcohol: Drinks/Week____ ☐ Stress level (rate 1 to10): _____

Are you pregnant? ☐ Yes ☐ No Due Date:_____

Injuries/Surgeries you have had: **Description** **Date**

Surgeries:_____

_____

Head Injuries: _____

Broken Bones/Dislocations: _____

MEDICATIONS: _____

_____

_____

_____

_____

VITAMINS/SUPPLEMENTS:_____

_____

_____

_____

_____