CONFIDENTIAL NEW PATIENT INFORMATION

Name: _____ Date: _____

Address: _____ City/State _____ Zip: _____

Phone (Home): _____ (Cell) _____

E-Mail Address (Please Print): _____

Birth Date: _____ Sex: M / F Medicare: Y / N Work Injury Y / N

Employer: _____ Work Phone: _____

Referred by: _____

Primary Health Concerns:

1. _____

2. _____

3. _____

Prior Chiropractic experience? Y / N

If Yes, Please estimate the date of last treatment. _____

Illness/Location of Pain: _____

Accident: _____

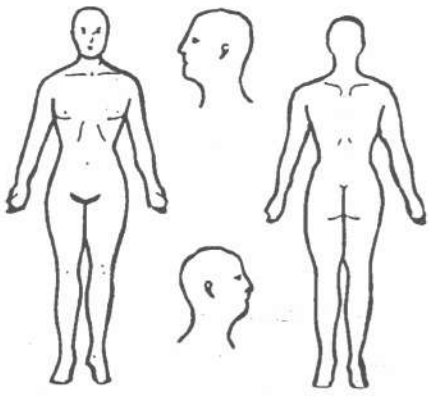
Previous Treatment and Doctor's Name: _____

Medications: _____

Have you ever suffered from: (Check Boxes)

- ☐ Dizziness
- ☐ Heart Trouble
- ☐ Diabetes
- ☐ Headaches
- ☐ Asthma
- ☐ Sinus Trouble
- ☐ Cancer
- ☐ Chronic BackProblems
- ☐ Circulatory Problems
- ☐ Arthritis/Joint Aches
- ☐ Numbness/Tingling
- ☐ Digestive Disorders
- ☐ Anxiety/Depression
- ☐ Low Energy/Fatigue
- ☐ Back Surgery

MARK SYMPTOM AREAS



MEASURE THE AMOUNT OF PAIN YOU HAVE BEEN EXPERIENCING WITH AN "X" ON THE SCALE:

NO PAIN _____ EXTREME PAIN

ACKNOWLEDGMENT OF PRIVACY PRACTICES

I, _____, understand that this office has a privacy policy in effect. Your signature does not release information to anyone.

PATIENT'S NAME _____ DATE: _____