

New Patient Information

Date ____/____/____
Patient number _____

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work phone _____

Cell Phone _____ Email Address _____

Would you like to receive text or email appointment reminders? Y/N

Occupation _____ Last four of social security # _____

Emergency Contact: _____ Phone _____

Marital Status (circle one): Single/Married/Divorced/Widowed/Legally Separated

Spouse's Name _____

How did you hear about us?

Referred by: Patient Name _____ Physician Name _____

Yellow Pages/Insurance Company/Other _____

Consent of Treatment of a Minor:

I hereby authorize First Choice Chiropractic and whomever he/she may designate to assist and administer chiropractic and physical care as he/she deems necessary to my son/daughter.

Parent Signature _____ Date _____

Females Only

I, _____, to the best of my knowledge confirm that I am not pregnant and waive all responsibility to the Doctor.

Signature _____ Date _____

Please list your major complaints in order of severity:

1. _____
2. _____
3. _____
4. _____

Is this condition Work Related? _____ Automobile Accident? _____ Home Injury? _____ Other: _____

Date of Accident _____

When did this condition develop? _____ Did it develop? (Circle one) Immediately/Gradually?

What is the exact location of your symptoms? _____

Briefly Describe: _____

What do you think caused this condition? _____

How often do you experience these symptoms? (Circle one)

Constant Frequent (75%) Often (50%) Seldom (25%) Rarely (less than 25%)

What is the type of pain you are experiencing? (Circle all that apply)

Dull Sharp Burning Aching Stabbing Throbbing

Are you experiencing any of the following (Circle all that apply)? Tingling Numbness Twitching

Rate your symptoms on a scale of 1-10 (circle one) minimal 1 2 3 4 5 6 7 8 9 10 severe

Does the pain travel or radiate to another area of your body? YES ___ NO ___

If yes, what area? _____

What provokes or aggravates your condition (circle all that apply)?

Sitting	Pushing	Hot	Mental Activities
Standing	Pulling	Cold	Bright Lights
Walking	Lifting	Sneezing	
Lying	Gripping	Bowel Movements	
Other _____			

What helps alleviate pain (circle all that apply)?

Sitting	Walking	Rest	Cold
Standing	Lying	Hot	

Is the condition interfering with your work? _____ sleep? _____ daily routine? _____ other? _____

Please Explain: _____

Please list all medications (prescribed or over the counter) you are currently taking for this condition: _____

Please list any doctors that you have seen for this condition (Include doctor's name, diagnosis, treatment received, and any change in your condition since you have received treatment):

Patient Name _____

HEALTH HISTORY:

Please check any condition you have had or currently have:

- | | | |
|---|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Bladder Trouble |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Rheumatic Disease | <input type="checkbox"/> Erectile Dysfunction |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Menstrual Irregularity |
| <input type="checkbox"/> Neurological Disorders | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Other, _____ |

FAMILY HISTORY

Have any of your family members ever suffered from the following conditions:

- Diabetes
 Heart Disease
 Stroke
 Neurological Disorders (describe) _____
 Autoimmune Disorders (describe) _____
 Cancer (what kind) _____

EXAMINATIONS AND TESTS:

Name of Family Doctor _____ May we contact them? _____

Have you been treated by a chiropractor and/or Physical Therapist during this calendar year for any type of injury?
Yes/No Specify _____

Have you had an x-ray in the last 5 years? Yes/No Date: _____ Results: _____

Have you had an MRI or Nerve Conduction Study in the last 5 years? Yes/No Date: _____
Results: _____

Any other diagnostic tests:

List any fall, surgeries, hospitalizations, or accidents in the last year:

I understand and agree that health insurance policies are an arrangement between me, my employer, and my health insurance carrier. The practitioners at First Choice Chiropractic office do not participate in all HMO/PPO organizations. I understand that the Doctor's office will accept assignment directly from my insurance company. However, I clearly understand and agree that all services rendered to me are ultimately my responsibility and I am personally responsible for payment of all services rendered.

Patient Signature _____ Date _____

**The following questions are required as a result of the Affordable Healthcare Act.
Thank you for your cooperation.**

Race (Please circle only one):

- American Indian or Alaska Native Caucasian/ White Native Hawaiian or Other Pacific Islander
- African American/Black Hispanic or Latino Not Provided
- Asian

Ethnicity: (Please circle only one)

- Hispanic or Latino Not Hispanic or Latino Not Provided

Preferred Language: _____

LIST ANY AND ALL ALLERGIES TO MEDICATIONS

- 1. _____
- 2. _____
- 3. _____
- 4. _____

LIST ALL MEDICATIONS TAKEN AND FOR WHAT CONDITIONS:

- Name: _____ Dosage: _____ Frequency: _____ For What: _____
- Name: _____ Dosage: _____ Frequency: _____ For What: _____
- Name: _____ Dosage: _____ Frequency: _____ For What: _____
- Name: _____ Dosage: _____ Frequency: _____ For What: _____
- Name: _____ Dosage: _____ Frequency: _____ For What: _____

CONSENT TO ACCESS MEDICATION HISTORY:

I authorize First Choice Chiropractic to retrieve my medication history from the SureScripts website, Dr First:
Patient Signature: _____

LIST ALL VITAMINS AND MINERALS TAKEN AND FOR WHAT CONDITIONS:

- Name: _____ Dosage: _____ Frequency: _____ For What: _____
- Name: _____ Dosage: _____ Frequency: _____ For What: _____
- Name: _____ Dosage: _____ Frequency: _____ For What: _____
- Name: _____ Dosage: _____ Frequency: _____ For What: _____
- Name: _____ Dosage: _____ Frequency: _____ For What: _____

SMOKER STATUS(For all Patients over age 13):

- Are you a smoker? YES/NO If yes, how many cigarettes per day? _____
- Were you a smoker? YES/NO If yes, when did you quit? _____
- Are you a "Never smoker"? (Less than 100 cigarettes in a lifetime) YES/NO

EXERCISE: Do you exercise at a moderate intensity a minimum of 3 x per weeks? Yes or No (circle one)

Current Height: _____
Current Weight: _____