



**SOUTHCOAST SPINE SPECIALIST
DR. JOHN P. TSONIS**

NEW PATIENT HEALTH INFORMATION QUESTIONNAIRE

IF YOU HAVE ANY DIFFICULTY FILLING OUT THIS INFORMATION PLEASE FEEL FREE TO ASK FOR ASSISTANCE

PATIENT INFORMATION (Please Print)

Name _____ Date _____ SSN _____

Address _____ City _____ State _____ Zip _____

Sex: Male/Female Birthday _____ E-mail _____

Home Phone(____) _____ Cell Phone(____) _____ Work Phone(____) _____

Employer/School _____ Occupation _____

Employer Address _____ City _____ State _____ Zip _____

Who may we thank for referring you to us? _____

Person to contact in case of emergency? _____

Marital Status (Circle One)? Married Widowed Single Minor Separated Divorced Partnered

INSURANCE INFORMATION: PLEASE PRESENT YOUR INSURANCE CARDS AND DRIVERS LICENSE TO ENSURE WE HAVE THE PROPER INFORMATION FOR BILLING PURPOSES.

HEALTH INFORMATION

Reason for visit (be specific)? _____

What makes you symptoms worse? _____

What makes your symptoms better? _____

Have you received any prior treatment for your symptoms? Y/N Explain: _____

Have you seen a chiropractor for this condition or another condition? Y/N Was it a positive experience? Y/N

Who is your primary care physician? _____ Do you mind if we contact Him/Her? Y/N

Date of last Physical _____

(Women) Are you pregnant? : Y/N Nursing? : Y/N Taking birth control? : Y/N

List any surgeries (including minor surgeries) _____

List all Medications and Supplements you take:

Do you take blood thinners? Y/N Do you smoke? Y/N Do you drink more than socially? Y/N

Do you exercise? Y/N What type of exercise do you do? _____

HEALTH HISTORY (PLEASE MARK ONLY APPLICABLE CONDITIONS)

Y/N AIDS/HIV	Y/N Headaches	Y/N Pacemaker
Y/N Alcoholism	Y/N Heart Disease	Y/N Pinched Nerve
Y/N Arthritis	Y/N High Blood Pressure	Y/N Prostate Problems
Y/N Bleeding Disorders	Y/N Hernia	Y/N Prosthesis
Y/N Cancer (Specify) _____	Y/N Herniated Disc	Y/N Rheumatoid Arthritis
Y/N Depression	Y/N Herpes	Y/N Stroke
Y/N Diabetes	Y/N Kidney Disease	Y/N Thyroid Problems
Y/N Epilepsy	Y/N Liver Disease	Y/N Tumors/Growths
Y/N Fractures	Y/N Multiple Sclerosis	Y/N Venereal Disease
Y/N Goiter	Y/N Osteoporosis	Y/N Other _____

The above information is answered to the best of my ability and I do understand that all the information is important for my safety through the course of chiropractic treatment. I do acknowledge that it is my responsibility to inform the doctor of any changes in my health information or the information of my minor child. I also understand that all the information provided is kept highly confidential and will be used for office, billing and insurance purposes only and I acknowledge that Mellody Chiropractic and Dr. John Tsonis does have their entire privacy policy available for my review at any time.

The above named doctor may use my health information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. The consent will end upon my request or if the doctor determines my release from treatment.

I hereby understand and accept care provided by Mellody Chiropractic and Dr. John Tsonis which will consist of but not limited to Spinal X-Rays, Chiropractic Diagnosis, Chiropractic Adjustments and Therapeutic Modalities that are warranted for my specific care. I also acknowledge that Chiropractic care is not a cure of any diseases and is only for treatment of conditions that are related to vertebral subluxations. Spinal X-Rays will be used for the sole purpose to analyze and diagnose vertebral subluxation to confirm and justify spinal adjustments. Any non-chiropractic findings will be referred to the proper physician for analysis. I also authorize Mellody Chiropractic and Dr. John Tsonis to use my X-Rays for teaching purposes and for consultation with other doctors.

This signature is also for purposes of filing insurance claim forms. It will allow Mellody Chiropractic to file forms using Signature on File (SOF) instead of having me sign the insurance forms after each visit.

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

DATE

PLEASE PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

RELATIONSHIP TO PATIENT