

DATE: _____

LAST NAME: _____ FIRST _____ MI. _____

ADDRESS: _____

CITY _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK: _____ CELL: _____

SEX: M / F _____ MARRIED/ SINGLE DOB: _____ SSN: _____

EMPLOYER: _____

E-MAIL : _____

SPOUSE'S NAME: _____ SPOUSE DOB: _____

SPOUSE'S EMPLOYER: _____

*Is this consultation due to an AUTO ACCIDENT or WORKER'S COMPENSATION? YES _____ NO _____
If yes which one? _____ What was the DATE OF THE INCIDENT? _____

**How were you referred to us? _____

BILLING INFORMATION

_____ I have no insurance coverage and I understand that I will be responsible for my account. I also understand that payment is expected at time of service.

Name of Primary Ins. Company: _____

Name of Insured: _____ Insured DOB: _____

Policy #: _____ Group: _____

Relationship to Insured: Self _____ Spouse _____ Child _____

Name of Sec. Ins. Company: _____

Name of Insured: _____ Insured DOB: _____

Policy #: _____ Group: _____

Relationship to Insured: Self _____ Spouse _____ Child _____

* Please be advised that it is your responsibility to pay any additional costs not covered by your Insurance Company.

I hereby state that all the information given is complete and correct to the best of my knowledge.

SIGNATURE

DATE

No minor will be treated unless this form is signed by a legal guardian.

I hereby authorize the doctors and whomever they designate as their assignment, to administer treatment as they so deem necessary to my child.

SIGNATURE

DATE

NEW PT. FORM

WOMAN ONLY

Is there a confirmed or suspected pregnancy at this time? YES NO Due Date: _____

**If you become pregnant or suspect a pregnancy at any time during the course of your treatment, please notify the doctor and the therapist.

Mark the area on the body where you feel the described sensations. Use the appropriate symbol. Include all affected areas.

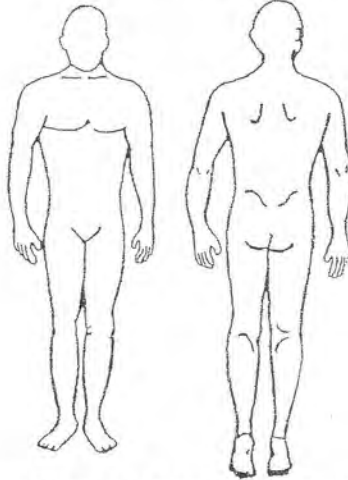
Numbness =====

Burning xxxxx

Dull Pain ////

Pins & Needles oooo

Stabbing +++++



Health Information

Major Complaint: _____

Types & dates of surgeries: _____

List any implanted devices and their locations: _____

Please list any medications being taken: _____

Have you had chiropractic care before: _____ Name of previous doctor: _____

Please check all of the following health symptoms that you may be experiencing:

- Headaches
- Neck Pain
- Stiff Neck
- Sleep Problems
- Back Pain
- Nervousness
- Tension
- Irritability
- Chest Pains
- Shoulder Pain
- Dizziness
- Head seems heavy
- Pins/Needles Arms

- Pins/Needles Legs
- Numbness in Fingers
- Numbness in Toes
- Short of breath
- Fatigue
- Depression
- Knee Pain
- Light hurts eyes
- Loss of memory
- Ears ringing
- Face Flushes
- Buzzing in ears
- Loss of balance

- Fainting
- Loss of smell
- Loss of taste
- TMJ Pain
- Diarrhea
- Feet cold
- Hands cold
- Stomach upset
- Constipation
- Cold sweats
- Hiatal hernia
- Allergies
- Joint pain

Comments: _____