



New Patient Information

Personal Information	Name: _____ Spouse/Partner: _____ Address: _____ City: _____ State: _____ Zip: _____ Email: _____ Cell Phone: _____ Cell Phone Carrier: _____ Home Phone: _____ Work Phone: _____ Age: _____ Birth date: _____ Gender: M F Marital Status: M S W D Number of Children and Ages: _____ Employer: _____ Position: _____ In Case of Emergency, Notify: _____ Phone: _____ Primary Care Physician: _____ Who Should We Thank For Telling You About Our Office? _____ What is the best way for you to receive appointment reminders? (circle one) <div style="display: flex; justify-content: space-around; margin-top: 10px;"> Phone Email Text </div>
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Insurance Information	Insurance Company: _____ Name of Primary Card Holder: _____ Birth Date: _____ Card Holder's Place of Employment: _____
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Current Health Concern	Reason for today's visit: _____ <div style="text-align: center; margin-top: 10px;"> Level of Discomfort 1 2 3 4 5 6 7 8 9 10 Mild Severe </div> Date Symptoms First Appeared: _____ Is this condition: ___ Work Related ___ Fall/Injury ___ Auto Accident ___ Other	
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Family History	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;"><u>Family Member</u></td> <td><u>Significant Past & Present Health Conditions (EX: Cancer, Heart Disease, Etc.)</u></td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </table>	<u>Family Member</u>	<u>Significant Past & Present Health Conditions (EX: Cancer, Heart Disease, Etc.)</u>	_____	_____	_____	_____	_____	_____
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_____	_____								
_____	_____								
_____	_____								

Past Health Events	Previous Surgeries: ___ Eyes/Ears/Nose/Throat ___ Head/Neck ___ Back/Spine			
	___ Chest/Heart/Lungs ___ Abdominal			
	___ Other: _____			
	Previous Fractures Or Broken Bones?	Yes	No	Explain: _____
	Previous Falls Or Accidents?	Yes	No	Explain: _____
	Previous Hospitalizations?	Yes	No	Explain: _____
	Previous Car Accidents?	Yes	No	Explain: _____
	Previous Chiropractic Care?	Yes	No	Explain: _____
	Do You Workout or Exercise?	Yes	No	Explain: _____
	Do You Take Any Medications?	Yes	No	List: _____
Do You Take Any Vitamins/Herbs?	Yes	No	List: _____	
Have You Ever Had X-Rays Taken?	Yes	No	Where: _____	
Date of Last Physical Exam: _____	Are You Pregnant?		Yes No	

Check All That Apply	Health Issues:				
	___ Polio	___ Arthritis	___ Diabetes	___ Sleeplessness	
	___ Cancer	___ AIDS or ARC	___ Heart	___ Chronic Fatigue	
	___ Frequent Illness	___ Allergies	___ High Stress	___ Poor Diet	
	___ Genetic Disorders	___ Epilepsy	___ Over Weight	___ Under Weight	
	___ Other: _____				
	Habits:	None	Light	Moderate	Heavy
	Alcohol	___	___	___	___
	Tobacco	___	___	___	___
	Drugs	___	___	___	___
Pain Relievers	___	___	___	___	
Caffeine	___	___	___	___	
Sleep	___	___	___	___	
Artificial Sweeteners	___	___	___	___	
Exercise	___	___	___	___	
Water	___	___	___	___	

Check Any Problem You Have Ever Suffered From	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Middle Back Pain	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Shoulder/Arm Pain
	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/> Hip/Leg Pain	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Lungs/Breathing
	<input type="checkbox"/> Blood Pressure	<input type="checkbox"/> Heart Rate	<input type="checkbox"/> Sinus Pain	<input type="checkbox"/> Sinus Infections
	<input type="checkbox"/> Eyes/Vision	<input type="checkbox"/> Throat/Voice	<input type="checkbox"/> Hearing	<input type="checkbox"/> Ear Infection
	<input type="checkbox"/> Dental/TMJ	<input type="checkbox"/> Headaches	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Numbness/Tingling
	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Depression
	<input type="checkbox"/> Fainting	<input type="checkbox"/> Cold Hands/Feet	<input type="checkbox"/> Seizures	<input type="checkbox"/> Stress Reactions
	<input type="checkbox"/> Shaking/Tremors	<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Nausea	<input type="checkbox"/> Excessive Thirst
	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Weight Loss/Gain
	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Change in Stools	<input type="checkbox"/> Genital Issues	<input type="checkbox"/> Pain With Urination
	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Infrequent Urination	<input type="checkbox"/> Weak Stream	<input type="checkbox"/> Bladder Control
	<input type="checkbox"/> Menstrual	<input type="checkbox"/> Fertility Issues	<input type="checkbox"/> Lumps (Breast/Genital)	

All Information on This Form is Confidential	
I certify that I have completed this form to the best of my ability, and the statements I have provided are true.	
Patient/Guardian Signature: _____	Date: _____