New Patient Application

Personal Information

First Name: _____ Middle Name:_____

Last Name: _____

Gender: ☐ Male ☐ Female

Cellphone: _____ Alternate Phone: _____

Address: _____

_____

_____

E-mail: _____

Birth Date: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employment Information

Job Title: _____

Work Phone: _____

Insurance/Account Information

Person Responsible for this account: _____

Do you have Health Insurance? Yes ☐ No ☐

If so, who is the primary person listed on the Health Insurance Card?

☐ Self ☐ Someone Else

Primary Person's Name: _____

Employer through which Health Insurance is provided: _____

Additional Information

Number of Children: _____ Ages of Children: _____

Emergency Contact Name: _____

Emergency Contact Phone #: _____

Relationship to Patient: _____

Name of Primary Physician: _____

Primary Physician Phone #: _____

Is your current issue related to any of the following?

- ☐ Auto Accident
- ☐ Personal Injury Claim
- ☐ Workman's Compensation
- ☐ Medicare Coverage

The person filling in this form is the

- ☐ Patient (self)
- ☐ Father
- ☐ Mother
- ☐ Son/Daughter
- ☐ Guardian

How Did You Hear About Us?

How did you hear about us?

- ☐ Google
- ☐ Facebook
- ☐ Internet
- ☐ Patient
- ☐ Family
- ☐ Friend
- ☐ Doctor
- ☐ Our staff
- ☐ Health Fair
- ☐ Event
- ☐ Flyer
- ☐ email

Other: _____

Is there someone we may thank for telling you about our clinic:

_____

How Can We Help You Today?

Describe the primary reason(s) that you wish to see us:

_____

_____

How long have you had this? _____

How often does it occur? _____

What do you think caused the onset?

_____

IF you are experiencing pain or discomfort, how often do you experience this?

☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional

How would you rate the intensity of your pain or discomfort? _____ (0=none; 10=excruciating)

How would you best describe the sensation of the pain/symptom?

☐ Sharp ☐ Dull ☐ Aching ☐ Stabbing
☐ Burning ☐ Throbbing

Other: _____

If your pain or discomfort radiates or travels, please identify where to:

_____

What aggravates your discomfort or pain?

☐ Standing ☐ Lifting ☐ Time on Computer
☐ Walking ☐ Running ☐ Talking on Phone
☐ Stress ☐ Driving ☐ Getting in/out of Car
☐ Exercise ☐ Twisting ☐ Getting in/out of Bed
☐ Coughing ☐ Going up Stairs ☐ Repetitive Movement
☐ Sneezing ☐ Sitting

Other: _____

What relieves it or makes your feel better?

☐ Sleeping ☐ Standing ☐ Ice
☐ Heat ☐ Stretching ☐ Sitting
☐ Rest ☐ Medication ☐ Exercise
☐ Walking ☐ Analgesic ☐ Chiropractic Care
☐ BioFreeze ☐ Massage ☐ Resting in Recliner

Other: _____

Additional Information

Have you seen anyone for any of the conditions that you list as your current issues? ☐ Yes ☐ No

GENERAL…

Do you have a pacemaker? ☐ Yes ☐ No

Are you Pregnant? ☐ Yes ☐ No ☐ Maybe ☐ Don't Know

When was your last menstrual period: _____

YOUR WORK…

Describe your job: ☐ Sedentary ☐ Moderate activity ☐ Heavy labor ☐ Non-Working

Other: _____

EXERCISE…

Frequency of Exercise

☐ Never ☐ Rarely ☐ Occasionally ☐ Moderately ☐ Regularly

Intensity of Exercise

☐ Low Level ☐ Medium Level ☐ High Level ☐ Competition

Please list your favorite Sports & Activities:

_____

DIET, ALCOHOL, etc…

Do you have a well-balanced diet?

☐ Never ☐ Rarely ☐ Occasionally ☐ Moderately ☐ Yes

Describe your diet in a few words: _____

Do you drink caffeinated beverages on a daily basis?

☐ No ☐ Occasionally ☐ 1 to 2 ☐ 2 to 3 ☐ 4 to 5 ☐ 5+ per day

Do you drink alcoholic beverages?

☐ No ☐ Occasionally ☐ 1 to 2 ☐ 2 to 3 ☐ 4 to 5 ☐ 5+ per day

Do you use street drugs?

☐ Never ☐ Not anymore ☐ Occasionally ☐ Sometimes ☐ Yes

Do you use any tobacco products?

☐ Never ☐ Not anymore ☐ Occasionally ☐ Sometimes ☐ Yes

What type of tobacco? _____

MEDICAL CONDITIONS REVIEW (past & present)

Please check yourself and also indicate any family members **who have had or currently have** any of the listed conditions:
(Be sure to check the appropriate box – where **S** = Self; **G** = Grandparent; **P** = Parent, **C** = Child, **O** = Aunt or Uncle)

☐ S ☐ G ☐ P ☐ C ☐ O AIDS / HIV Positive
☐ S ☐ G ☐ P ☐ C ☐ O Alcoholism
☐ S ☐ G ☐ P ☐ C ☐ O Arthritis
☐ S ☐ G ☐ P ☐ C ☐ O Asthma
☐ S ☐ G ☐ P ☐ C ☐ O Bleeding or Clotting Disorders
☐ S ☐ G ☐ P ☐ C ☐ O Breast Disease
☐ S ☐ G ☐ P ☐ C ☐ O Cancer, please specify type below
☐ S ☐ G ☐ P ☐ C ☐ O Colitis or Crohn's Disease
☐ S ☐ G ☐ P ☐ C ☐ O Depression
☐ S ☐ G ☐ P ☐ C ☐ O Diabetes
☐ S ☐ G ☐ P ☐ C ☐ O Epilepsy or Seizures
☐ S ☐ G ☐ P ☐ C ☐ O Heart Disease
☐ S ☐ G ☐ P ☐ C ☐ O High Blood Pressure
☐ S ☐ G ☐ P ☐ C ☐ O Kidney or Liver Disease
☐ S ☐ G ☐ P ☐ C ☐ O Osteoporosis
☐ S ☐ G ☐ P ☐ C ☐ O Stroke

Add your notes here – also list any other conditions that we should be aware of

SURGERIES

List the year & type of each surgery that you have had, using 1 line for each. *Example: 1986 - Gall bladder removal*

List any surgeries (list "None" if not applicable)

If there are any lingering side-effects or issues from the above surgeries, please list them here:

HOSPITALIZATIONS

List the year & type of each hospitalization that you have had, using 1 line for each. *Example: 1986 - car accident recovery*

List any hospitalizations (enter "None" if not applicable)

CURRENT MEDICAL CARE

List any doctors that you are presently seeing or have seen in the last 6 months:

Doctor/Clinic Name | Last Visit (Month / Day / Year)

Nature of Visit

Doctor/Clinic Name | Last Visit (Month / Day / Year)

Nature of Visit

Doctor/Clinic Name | Last Visit (Month / Day / Year)

Nature of Visit

Doctor/Clinic Name | Last Visit (Month / Day / Year)

PRESCRIPTION DRUGS – List each prescription, dosage/strength, frequency and reason for taking:
Example: Celebrex - 200mg - 2x daily - arthritis relief

List of prescription drugs

Have you ever taken or do you now take any of the following drugs?

☐ Insulin ☐ Cortisone ☐ Thyroid Medicine ☐ Hormones
☐ Blood Pressure ☐ Tranquilizers ☐ Birth Control ☐ Sedatives

If so, please give dates taken (unless this is already listed above)

DRUG ALLERGIES – List all drug allergies and resulting side-effect:
Example: Sulfa drugs - severe skin rash

OTHER ALLERGIES - List all other allergies and resulting side-effect:
Example: Grass/Pollen - severe sneezing & respiratory difficulties