NEW PATIENT INFORMATION

Welcome to our office!
Please complete all questions.

Name: _____ **Date:** _____

Address: _____ **City/State/Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Email: _____ **Race:** _____

Birthdate: _____ **Age:** _____ **Social Security #:** _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow **Primary Care Physician:** _____

Your Employer: _____ **Occupation:** _____

Spouse's Name: _____ **Spouse's Employer:** _____

Children's Names and Ages: _____

Favorite Hobbies or Interests: _____

Method of Payment or Insurance Carrier: _____

Policy Holder/Guarantor Information (If other than self)

Name:_____

Address:_____

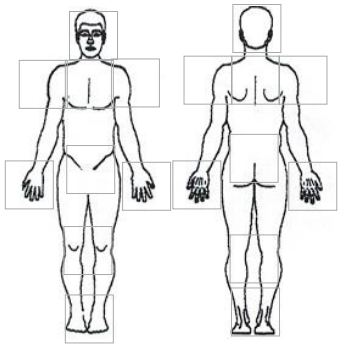
City, State, Zip:_____

Phone Number:_____

Birth Date:_____

Social Security #: _____

Mark an X on the picture where you have pain or other symptoms.



Describe your current problem and how it began: (circle one)

Headache ☐ **Neck Pain** ☐ **Mid-Back Pain** ☐ **Low Back Pain** ☐ **Other**_____

Have you had same or similar problem(s) before? _____ **If so for how long?**_____

Family members (immediate family) with similar problems? _____

Is this? ☐**Work Related** ☐**Auto Related** ☐**N/A**

Date problem began:_____

How problem began:_____

Other doctors you have seen for this problem?_____

Current complaint (how you feel today):

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain Unbearable Pain

How often are your symptoms present? (Please circle one)

(Occasional) 0-25%☐ **26-50%**☐ **51-75%** ☐ **76-100% (Constant)** ☐

In general would you say your overall health right now is:

Excellent ☐ **Very Good** ☐ **Good** ☐ **Fair** ☐ **Poor** ☐

Have you had spinal X-Rays, MRI, CT Scan for your area(s) of complaint? NO YES

Date(s) taken:_____ **What areas were taken?**_____

Please circle all of the following that apply to you:

Alcohol/Drug Dependance ☐
Recent Fever ☐
Diabetes ☐
High Blood Pressure ☐
Stroke (Date) _____ _____
Corticosteroid Use (Cortisone, Prednisone, etc.) ☐
Taking Birth Control Pills ☐
Dizziness/Fainting ☐
Numbness in Groin/Buttocks ☐
Cancer/Tumor (explain) ☐_____
_____
Osteoporosis ☐
Epilepsy/Seizures ☐
Other Health Problems (explain) ☐_____
_____

Prostate Problems ☐
Menstrual Problems ☐
Urinary Problems ☐
Currently Pregnant, # weeks_____
Abnormal Weight ☐ **Gain/Loss** ☐
Marked Morning Pain/Stiffness ☐
Pain Unrelieved by position or Rest ☐
Pain at Night ☐
Visual Disturbances ☐
Surgeries_____
_____
Tobacco Use-Type_____
Frequency_____**/Day**
Medications_____
_____

Family History (circle any that apply)

Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis ☐

Who may we thank for referring you? _____

Circle how you would like appointment reminders: ☐ **Phone** ☐ **Text** ☐ **Email**

Cell Phone Carrier (for text reminders only) _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to Complete Wellness Chiropractic and Rehabilitation. The patient understands and agrees to allow Complete Wellness Chiropractic and Rehabilitation to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

A patient, in coming to Complete Wellness Chiropractic and Rehabilitation, gives the doctor/therapist permission and authority to care for the patient in accordance with tests, diagnosis and analysis. The chiropractic adjustments, therapy, or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor/staff of course, will not give any treatment or health care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the doctor/staff. The staff at Complete Wellness Chiropractic and Rehabilitation provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician or therapist at Complete Wellness Chiropractic and Rehabilitation, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding treatment, will be explained to me upon my request.

Patient or Guardian Signature: Date: