

Welcome to New Life Chiropractic

1. ABOUT YOU

Today's Date: ___/___/___ File #: _____

Name: _____

What you prefer to be called: _____ Male Female

Date of Birth: ___/___/___ Age: _____ SS#: _____

Home Address: _____

City _____ State _____ Zip _____

Home Phone #: _____ Cell #: _____

Referred by: _____

Employer: _____ How Long? _____

Employer's Address: _____

City _____ State _____ Zip _____

Occupation: _____ Work Phone: _____

Marital Status: Single Married Divorced Separated Widowed

How many kids in the household: _____ Ages: _____

Spouse's Name: _____ Spouse's Work Phone: _____

Medical Physician's Name: _____

How many kids in the household: _____ Ages: _____

Spouse's Name: _____ Spouse's Work Phone: _____

2. INSURANCE INFO

Insurance Company Name: _____

Address: _____

Phone #: _____

Insured's SS #: _____

Group # (plan, local or policy #): _____

Insured Name: _____

Relationship: _____

Date of Birth: ___/___/___

Insured's Employer: _____

PLEASE INFORM THE FRONT DESK OF SECOND INSURANCE SOURCE.

Dig. X-Ray

3. REASON FOR VISIT

Have you had previous chiropractic care? _____ What is your major complaint? _____

Other complaints: _____ How did the condition develop? _____

Date of onset? _____ Have you had same or similar problems in the past? _____

Is this condition getting worse? Yes No Constant Comes & Goes

How long has it been since you really felt good? _____

What aggravates the condition? _____ Does anything offer relief? _____

Is this related to an auto accident or work injury? Yes No Please Specify: _____

Describe the discomfort: Sharp Dull Achy Throbbing Other _____

What percent of the time does this condition bother you? 0% 25% 50% 75% 100%

Rate the level of discomfort on a scale of 0-10 (0 = no pain, 10 = extreme pain) _____

Others who have treated you for this condition: _____

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4. Health History

Are you taking any of the following medications?

- Nerve Pills Pain Killers (including aspirin) Muscle Relaxers
- Stimulants Blood Thinners Tranquilizers Insulin
- Others: _____

Have you ever had any of the following diseases/medical conditions?

- | | | |
|--------------------------------|-----------------------------|-----------------------|
| Y N Heart Attack/Stroke | Y N Heart Surg/Pacemaker | Y N Heart Murmur |
| Y N Congenital Heart Defect | Y N Mitral Valve Prolapse | Y N Artificial Valves |
| Y N Alcohol/Drug Abuse | Y N Venereal Disease | Y N Hepatitis |
| Y N HIV/AIDS | Y N Shingles | Y N Cancer |
| Y N Frequent Neck Pain | Y N Emphysema/Glaucoma | Y N Anemia |
| Y N High/Low Blood Pressure | Y N Psychiatric Problems | Y N Rheumatic Fever |
| Y N Severe/Frequent Headaches | Y N Kidney Problems | Y N Ulcers/Colitis |
| Y N Fainting/Seizures/Epilepsy | Y N Sinus Problems | Y N Asthma |
| Y N Diabetes/Tuberculosis | Y N Difficulty Breathing | Y N Chemotherapy |
| Y N Lower Back Pain | Y N Artificial Bones/Joints | Y N Arthritis |

Please list any other serious medical condition(s) you have or ever have had: _____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.
- The doctor reserves the right to make any financial arrangements necessary to provide affordable care in the event of a hardship situation.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: ____/____/____

- I authorize the staff to perform any necessary services needed during diagnosis and treatment on my minor child.

Signature: _____ Date: ____/____/____