**New Patient Information** Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Patient number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like to receive text or email appointment reminders? Y/N Cell carrier \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status (circle one): Single/Married/Divorced/Widowed/Legally Separated

Spouse’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us?

Referred by: Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physician Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yellow Pages/Insurance Company/Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent of Treatment of a Minor:**

I hereby authorize First Choice Chiropractic and whomever he/she may designate to assist and

administer chiropractic and physical care as he/she deems necessary to my son/daughter.

Parent Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Females Only**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, to the best of my knowledge confirm that I am not pregnant and waive

all responsibility to the Doctor.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list your major complaints in order of severity**:**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this condition Work Related? \_\_\_\_\_ Automobile Accident? \_\_\_\_\_ Home Injury? \_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Accident\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did this condition develop?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Did it develop? (Circle one) Immediately/Gradually?

What is the exact location of your symptoms?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Briefly Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you think caused this condition?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you experience these symptoms? (Circle one)

Constant Frequent (75%) Often (50%) Seldom (25%) Rarely (less than 25%)

What is the type of pain you are experiencing? (Circle all that apply)

Dull Sharp Burning Aching Stabbing Throbbing

Are you experiencing any of the following (Circle all that apply)? Tingling Numbness Twitching

Rate your symptoms on a scale of 1-10 (circle one) minimal 1 2 3 4 5 6 7 8 9 10 severe

Does the pain travel or radiate to another area of your body? YES\_\_\_ NO\_\_\_

If yes, what area? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What provokes or aggravates your condition (circle all that apply)?

Sitting

Standing

Walking

Lying

Pushing

Pulling

Lifting

Gripping

Hot

Cold

Sneezing

Bowel Movements

Mental Activities

Bright Lights

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What helps alleviate pain (circle all that apply)?

Sitting

Standing

Walking

Lying

Rest

Hot

Cold

Is the condition interfering with your work?\_\_\_\_\_ sleep? \_\_\_\_\_ daily routine? \_\_\_\_\_ other? \_\_\_\_\_\_

Please Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all medications (prescribed or over the counter) you are currently taking for this

condition:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any doctors that you have seen for this condition (Include doctor’s name, diagnosis, treatment received, and any change in your condition since you have received treatment): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH HISTORY:**

Please check any condition you have had or currently have:

\_\_\_\_\_ Diabetes

\_\_\_\_\_ Heart disease

\_\_\_\_\_ Stroke

\_\_\_\_\_ Neurological Disorders

\_\_\_\_\_ Headaches

\_\_\_\_\_ Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Mental Disorders

\_\_\_\_\_ Thyroid Disease

\_\_\_\_\_ Rheumatic Disease

\_\_\_\_\_ Depression/Anxiety

\_\_\_\_\_ Sleeping Difficulties

\_\_\_\_\_ High Blood Pressure

\_\_\_\_\_ Epilepsy

\_\_\_\_\_ Incontinence

\_\_\_\_\_ Bladder Trouble

\_\_\_\_\_ Erectile Dysfunction

\_\_\_\_\_ Menstrual Irregularity

\_\_\_\_\_ Digestive Problems

\_\_\_\_\_ Drug Addiction

\_\_\_\_\_ Alcoholism

\_\_\_\_\_ Other, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY**

Have any of your family members ever suffered from the following conditions:

\_\_\_\_\_ Diabetes

\_\_\_\_\_ Heart Disease

\_\_\_\_\_ Stroke

\_\_\_\_\_ Neurological Disorders (describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Autoimmune Disorders (describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Cancer (what kind) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EXAMINATIONS AND TESTS:**

Name of Family Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we contact them? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been treated by a chiropractor and/or Physical Therapist during this calendar year for any type of injury?

Yes/No Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had an x-ray in the last 5 years? Yes/No Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had an MRI or Nerve Conduction Study in the last 5 years? Yes/No Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other diagnostic tests:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any fall, surgeries, hospitalizations, or accidents in the last year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I understand and agree that health insurance policies are an arrangement between me, my employer, and my health insurance carrier. The practitioners at First Choice Chiropractic office do not participate in all HMO/PPO organizations. I understand that the Doctor’s office will accept assignment directly from my insurance company. However, I clearly understand and agree that all services rendered to me are ultimately my responsibility and I am personally responsible for payment of all services rendered.**

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The following questions are required as a result of the Affordable Healthcare Act.**

**Thank you for your cooperation.**

**Race** (Please circle only one):

American Indian or Alaska Native

African American/Black

Asian

Caucasian/ White

Hispanic or Latino

Native Hawaiian or Other Pacific Islander Not Provided

**Ethnicity**: (Please circle only one)

Hispanic or Latino Not Hispanic or Latino Not Provided

**Preferred Language**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIST ANY AND ALL ALLERGIES TO MEDICATIONS**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIST ALL MEDICATIONS TAKEN AND FOR WHAT CONDITIONS:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_ Frequency:\_\_\_\_\_\_\_\_\_ For What: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_ Frequency:\_\_\_\_\_\_\_\_\_ For What: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_ Frequency:\_\_\_\_\_\_\_\_\_ For What: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_ Frequency:\_\_\_\_\_\_\_\_\_ For What: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_ Frequency:\_\_\_\_\_\_\_\_\_ For What: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT TO ACCESS MEDICATION HISTORY:**

I authorize First Choice Chiropractic to retrieve my medication history from the SureScripts website, Dr First:

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIST ALL VITAMINS AND MINERALS TAKEN AND FOR WHAT CONDITIONS:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_ Frequency:\_\_\_\_\_\_\_\_\_ For What: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_ Frequency:\_\_\_\_\_\_\_\_\_ For What: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_ Frequency:\_\_\_\_\_\_\_\_\_ For What: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_ Frequency:\_\_\_\_\_\_\_\_\_ For What: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_ Frequency:\_\_\_\_\_\_\_\_\_ For What: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SMOKER STATUS**(For all Patients over age 13):

Are you a smoker? YES/NO If yes, how many cigarettes per day? \_\_\_\_\_\_

Were you a smoker? YES/NO If yes, when did you quit?

Are you a “Never smoker”? (Less than 100 cigarettes in a lifetime) YES/NO

**EXERCISE**: Do you exercise at a moderate intensity a minimum of 3 x per weeks? Yes or No (circle one)

Current Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_