New Patient Health Record

Welcome to our office. Please complete the following questions.

3195 S. Bascom Ave. • Campbell, CA 95008 • 408-559-1662 • F: 408-559-0946

About the Patient

Name_____

Address_____

City_____ State_____ Zip_____

Home Phone (_____)_____

Cell Phone (_____)_____

Birthdate_____Age_____Gender ☐M ☐F

Employer_____

Type of Work _____

Work Phone (_____)_____

Marital Status ☐Single ☐Married ☐Divorced

Social Security #_____ # of kids_____

Email Address_____

Do you have health insurance? ☐Yes ☐No

Carrier:_____

If yes, please bring your card to the initial exam.

Experience With Chiropractic

Who referred you here?_____

Have you ever been to a Chiropractor? ☐Y ☐N

Dr's Name_____

How often did you go?_____

When was your last visit?_____

Did you bring your family? ☐Yes ☐No

About the Spouse or Parent

Name_____

Employer_____

Type of Work_____

Work Phone (_____)_____

Cell Phone (_____)_____

Please mark any health challenges you suffer from:

☐Headaches	☐Neck Pain	☐Mid-back Pain	☐Low Back Pain
☐Migraines	☐Allergies/Sinus	☐Asthma	☐Indigestion/Heartburn
☐Tight Muscles	☐Fatigue	☐Trouble Sleeping	☐Frequent Colds/Flu
☐Ear Infections	☐Cramps	☐Dizziness	☐High Blood Pressure
☐Arthritis	☐Infertility	☐Constipation	☐Osteoporosis
☐Anxiety	☐Depression	☐ADD/ADHD	☐Weight Management
Tingling/Numbness:	☐Arms/Hands	☐Legs/Feet	☐Other_____

Health Habits

Do you smoke? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No

If yes, how many days a week? _____ What type of exercise?_____

Are you happy with your current weight? ☐ Yes ☐ No

What is your current weight?_____ What would you like it to be? _____

Would you like us to help you? ☐ Yes ☐ No

How many hours do you sleep a night?_____ Is your sleep ever disrupted?_____

What would you rate your stress on a scale of 1 to 10? (10 being the worst)_____

What is the biggest source?_____

Please list any medications you are taking:_____

Are your health challenges related to a recent accident? Yes No

Terms of Acceptance

Chiropractic has only **one goal**, and that is to remove nerve interference caused by a misalignment of spinal bones. It is important that you understand diagnosing conditions, treating conditions, and removing pain is **not** the objective of this office and that removing nerve interference through specific chiropractic care is the **only** goal of this office. Although this office may relieve you of some pain, maintaining your health through regular spinal adjustments is our primary concern.

It is agreed and understood that x-rays may be necessary to analyze the spine for vertebral subluxation and to determine the appropriateness of chiropractic spinal adjustments. To the best of my knowledge, I am not pregnant at this time. If the doctor discovers a non-chiropractic 'unusual finding'; I will be informed. It is completely my responsibility to follow up accordingly with a different health care provider. I also understand that **seeking advice from another health care provider cannot and should not interfere with the subluxation corrective care provided by this office.** It is also understood that payments to this office for x-rays are for the taking and examination of x-rays only. The film data will remain property of this office. They are kept on file where they may be seen at any time while I am a patient of Chiropractic First in Campbell, CA.

I fully understand the above and consent to Chiropractic care and spinal x-rays.

_____ _____

Patient Signature **Date** **Guardian/Spouse's Signature** **Date**