New Patient Information Form

central texas chiropractic & rehab

Doctor **Date**

Name	Preferred Name
Address	
City, State	Zip Code
Home Phone	Cell Phone
Email Address	
Social Security Number	Birth Date Age
Occupation	Employer
Is it okay to contact you at work? ❑ Yes ❑ No	Work Phone
Favorite Hobbies or Interests	
Marital Status ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed	
Spouse's Name	Phone Number/s
Children's Names and Ages	
Name of Emergency Contact	
Relationship	Phone Number/s

Which doctor do you prefer? ❑ Dr. Julie Restall, D.C. ❑ Dr. Hollis Wilson, D.C. ❑ No Preference
How did you find out about our office?
Have you ever had chiropractic care before? ❑ Yes ❑ No
If Yes, please tell us the doctor's name
Were you pleased with your care? ❑ Yes ❑ No
Are you receiving care from other health care professionals? ❑ Yes ❑ No
If Yes, please name them and their specialty
Please list any drugs or medications you are taking
Please list any vitamins/herbs/homeopathics/other you are taking

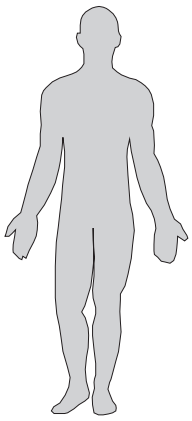
What Brings You Here?

Is this appointment related to ❑ Car Accident ❑ Workers Comp ❑ Other:

What is your primary reason for today's visit?

Is it ❑ Getting Worse ❑ Improving ❑ Intermittent ❑ Constant ❑ Can't Say

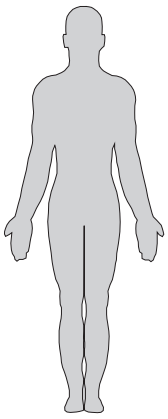
Where is the problem? Please use the illustrations and lines below to explain



Front

Front

Back



Back

When did the problem start?

Do you have ❑ Pain ❑ Numbness ❑ Tingling ❑ Aches

Is your pain ❑ Sharp ❑ Dull ❑ Throbbing ❑ Constant ❑ Intermittent

Are your symptoms affected by ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying down ❑ Weather

Please explain

Do you feel ❑ Cramps ❑ Burning ❑ Swelling ❑ Stiffness ❑ Other:

Do your symptoms interfere with ❑ Work ❑ Sleep ❑ Day-to-day Activities ❑ Play ❑ Other:

Please explain

On a scale of 1 to 10 (*1 least, 10 most*) please rate the severity of your symptoms 1 2 3 4 5 6 7 8 9 10

Any additional complaints/concerns you would like addressed

Previous interventions, treatments, medications, surgery or care you've sought for your complaint

Health History

Do you currently have, or have you had, any of the following (please check ☑ all that apply)

❑ Pneumonia	❑ Influenza	❑ Mumps	❑ Rheumatic Fever	❑ Smallpox
❑ Pleurisy	❑ Chickenpox	❑ Polio	❑ Thyroid Disease	❑ Diabetes
❑ Epilepsy	❑ Depression	❑ Cancer	❑ Whooping Cough	❑ Anemia
❑ Eczema	❑ Arthritis	❑ Measles	❑ Heart Disease	❑ Rashes

If you have ever been diagnosed with another disease or condition, please describe

Please check ☑ all items that are part of your lifestyle

❑ Caffeine	Number of drinks per day:	❑ Alcohol	Number of drinks per day:
❑ Cigarettes	Number of cigarettes per day:	❑ Artificial Sweeteners	
❑ Recreational Drugs	If Yes, please explain:		

Do you currently have, or have you had, any of the following (please check ☑ all that apply)

❑ Neck Pain	❑ Stuffy Nose	❑ Discolored Urine	❑ Low Back Pain
❑ Allergies	❑ Gas/Bloating After Meals	❑ Headache	❑ Fainting
❑ Heartburn	❑ Migraines	❑ Weight Loss	❑ Colitis
❑ Arm/Back Tingling	❑ Poor Appetite	❑ Irritable Bowel	❑ Shoulder Pain
❑ Excessive Appetite	❑ Black or Bloody Stools	❑ Hand Pain/Tingling	❑ Nervousness
❑ Constipation	❑ Leg Pain/Tingling	❑ Confusion	❑ Hemorrhoids
❑ Jaw Pain	❑ Depression	❑ Liver Problems	❑ Chest Pain
❑ Dental Problems	❑ Stroke	❑ Lung Problems	❑ Excessive Thirst
❑ Paralysis	❑ Heart Problems	❑ Frequent Nausea	❑ Tingling
❑ Abnormal Blood Pressure	❑ Vomiting	❑ Numbness	❑ Irregular Heartbeat
❑ Prostate Problem	❑ Fatigue	❑ Ankle Swelling	❑ Breast Pain/Lump
❑ Dizziness	❑ Cold Extremities	❑ Cramps	❑ Loss of Sleep
❑ Blurred Vision	❑ Painful Urination	❑ Difficulty Hearing	❑ Vision Problems
❑ Bladder Trouble	❑ Ear Pain	❑ Difficulty Breathing	❑ Excessive Urination

If applicable, date of last menstrual period

Are you pregnant? ❑ Yes ❑ No If Yes, what month?

Past injuries can affect present health. Please check ☑ all that apply

❑ Car Accidents	❑ Falls	❑ Sports Injuries	❑ Broken Bones
❑ Dislocations	❑ Spinal Tap	❑ Surgery	❑ Traction
❑ Use/d a Cane or Walker	❑ Extensive Dental Work	❑ Head Injuries/Knocked Unconscious	

If Yes to any of the above, please describe and include dates

What Do You Know About Chiropractic?

In your own words, what do chiropractors do?

What would you like to gain from chiropractic care (what are goals for treatment)?

Financial Responsibility

Self paying patients are responsible for payment **AT TIME OF SERVICE.**

If I am using insurance for partial payment, I authorize the release of information and understand that I or my parent/guardian (if patient is under 18 years old) will be responsible for payment of any amounts that my insurance company does not cover. This means that I will be responsible for my deductible, co-pay, co-insurance, or any services denied by my insurance for any reason.

I understand verification of benefits is not a guarantee of payment by my insurance company.

patient signature _____ date _____

signature of parent/guardian (if patient is under 18 years old) _____ date _____