Instructions for filling out New Patient Paperwork

Form #1: - This is our Confidential Patient Information Sheet (note: 2 pages) fill this form out to the best of your ability. Page 2: If this is an accident or a work related injury, please fill out the bottom part. Either way, sign and date the bottom.

Form #2: This form is called the Symptoms of Spinal Misalignment Questionnaire. Please read through and check the boxes on the right column to indicate any symptoms related to you.

***Be sure to bring your Driver's License & Insurance Card (If Applicable) with you.**

We look forward to seeing you! ☺

Date: _____

CONFIDENTIAL PATIENT INFORMATION

Name: _____ (Age) _____ Gender: M F

Home Address: _____ Home Phone: ( ) _____

City, State, Zip: _____ Work Phone: ( ) _____

Email Address: _____ Cell Phone: ( ) _____

Birth Date: _____/_____/_____ Social Security #: _____-_____-_____ Marital Status: S M D W

Names of Children: _____ Ages: _____

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Cell Phone: ( ) _____

How were you referred to this office? _____

PURPOSE OF THIS VISIT

Reason for this visit – Main Complaint: _____

Other Complaints: _____

When did this condition begin? _____/____/_____ Did it begin: Gradual Sudden Progressive over time

What activities aggravate your symptoms? _____

Is there anything, which has relieved your symptoms? Yes No Describe: _____

Type of Pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting Other _____

Does the Pain Radiate into your: ___Arm ___Leg ___Does not radiate Is this condition getting worse? Yes No

How often do you experience these symptoms? _____

Does complaint(s) interfere with: __Work __Sleep __Hobbies __Daily Routine Explain: _____

Have you experienced this condition before? Yes No If so, please explain: _____

Who have you seen for this? _____ What did they do? _____

How did you respond? _____

Do you have any other symptoms? ☐ Yes ☐ No If yes, please explain _____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? Yes No Who? _____ When? _____

Reason for visits: _____

How did you respond? _____

Did your previous chiropractor take before and after x-rays? Yes No

HEALTH HISTORY & LIFESTYLE

Do you exercise? Yes No How often?_____ What activities? Running Jogging Weight Training Cycling Yoga Pilates Swimming

Do you smoke? Yes No How much? _____

Do you drink alcohol? Yes No How much / week? _____

Do you drink coffee? Yes No How many cups / day? _____

Please list any health conditions not mentioned: _____

Please list any medications currently taking and their purpose : _____

Please list all past surgeries: _____

Please list all previous accidents and falls: _____

Have you or anyone in your immediately family ever been diagnosed with any of the following health conditions:

☐ Neurological Problems ☐ Heart Disease ☐ Respiratory Disease ☐ Gastrointestinal Problems ☐ Diabetes
☐ Rheumatoid Arthritis ☐ Multiple Sclerosis ☐ Cancer

If yes, please explain_____

_____

ACCIDENT OR WORK RELATED INJURIES

Is your condition accident or work related? ☐ Yes ☐ No

Date of injury_____ Location of injury (address)_____

Have you notified your supervisor? ☐ Yes ☐ No Name_____

What was done for you there?_____

Did you return to work? ☐ Yes ☐ No If so, when?_____

How long were you off work?_____ Any previous work injuries? ☐ Yes ☐ No

Have you obtained an attorney? ☐ Yes ☐ No Attorney's name_____

Attorney's address_____ Phone #_____

IF YOU ARE FILING UNDER INSURANCE, PLEASE PRESENT INSURANCE CARD AND DRIVER'S LICENSE FOR XEROX COPY

I understand and agree that health and accident insurance are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that ALL SERVICES ARE DUE AND PAYABLE AT THE TIME OF SERVICES. If payment arrangements are made and my care and treatment are suspended or terminated, any fees for professional services rendered to me will be immediately due and payable in full.

PATIENT SIGNATURE:_____ DATE:_____

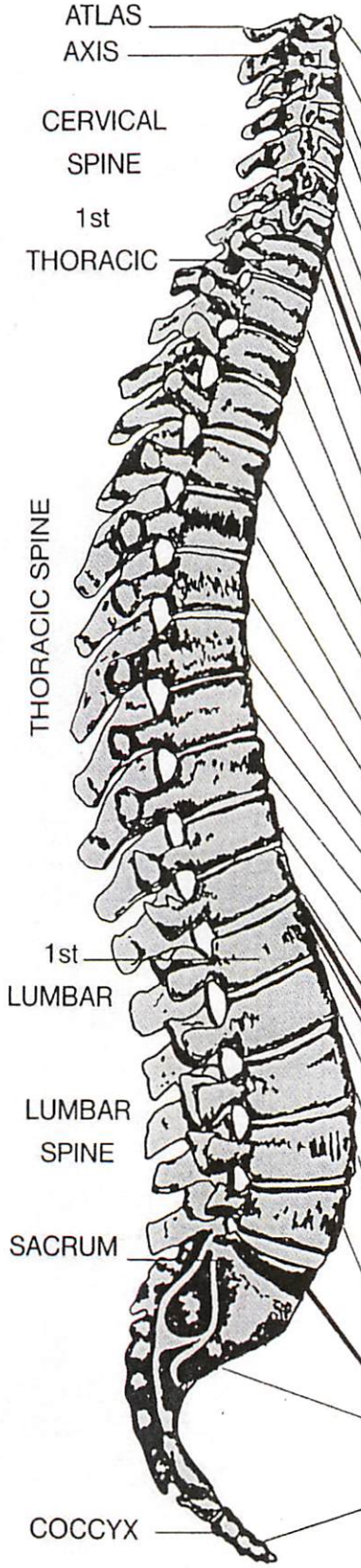
Signature of Gaurdian:_____DATE:_____

Please check any health condition you may be experiencing, now or in the past on the next page.

SYMPTOMS OF SPINAL MISALIGNMENT QUESTIONNAIRE

"The nervous system controls and coordinates all organs and structures of the human body." (*Gray's Anatomy*, 29th Ed., page 4). Misalignments of spinal vertebrae and discs may cause irritation to the nerves which could affect the areas listed. Please help us help you by placing a check mark in the appropriate box under the "Possible Effects" column to indicate your symptoms.

Please Check Below



Vertebrae	Areas Controlled by Nerves*	Possible Effects of a Malfunction	
1C	Blood supply to the head, pituitary gland, scalp, bones of the face, brain, inner and middle ear, sympathetic nervous system.	☐ headaches, ☐ nervousness, ☐ insomnia, ☐ head colds, ☐ high blood pressure, ☐ migraine headaches, ☐ nervous breakdowns, ☐ amnesia, ☐ chronic tiredness, ☐ dizziness.	NECK REGION
2C	Eyes, optic nerves, auditory nerves, sinuses, mastoid bones, tongue, forehead.	☐ sinus trouble, ☐ allergies, ☐ pain around the eyes, ☐ earache, ☐ fainting spells, ☐ certain cases of blindness, ☐ crossed eyes, ☐ deafness.	
3C	Cheeks, outer ear, face bones, teeth, tri-facial nerve.	☐ neuralgia, ☐ neuritis, ☐ acne or pimples, ☐ eczema.	
4C	Nose, lips, mouth, eustachian tube.	☐ hay fever, ☐ runny nose, ☐ hearing loss, ☐ adenoids.	
5C	Vocal cords, neck glands, pharynx.	☐ laryngitis, ☐ hoarseness, ☐ throat conditions such as sore throat or quinsy.	
6C	Neck muscles, shoulders, tonsils.	☐ stiff neck, ☐ pain in upper arm, ☐ tonsillitis, ☐ chronic cough, ☐ croup.	
7C	Thyroid gland, bursae in the shoulders, elbows.	☐ bursitis, ☐ colds, ☐ thyroid conditions.	
1T	Arms from the elbows down, including hands, wrists, and fingers; esophagus and trachea.	☐ asthma, ☐ cough, ☐ difficult breathing or shortness of breath, ☐ pain in lower arms and hands.	MID-BACK
2T	Heart, including its valves and covering; coronary arteries.	☐ functional heart conditions and certain chest conditions.	
3T	Lungs, bronchial tubes, pleura, chest, breast.	☐ bronchitis, ☐ pleurisy, ☐ pneumonia, ☐ congestion, ☐ influenza.	
4T	Gall bladder, common duct.	☐ gall bladder conditions, ☐ jaundice, ☐ shingles.	
5T	Liver, solar plexus, circulation (general).	☐ liver conditions, ☐ fevers, ☐ blood pressure problems, ☐ poor circulation, ☐ arthritis.	
6T	Stomach.	☐ stomach troubles or nervous stomach, ☐ indigestion, ☐ heartburn, ☐ dyspepsia.	
7T	Pancreas, duodenum.	☐ ulcers, ☐ gastritis.	
8T	Spleen.	☐ lowered resistance.	
9T	Adrenal and supra-renal glands.	☐ allergies, ☐ hives.	
10T	Kidneys.	☐ kidney troubles, ☐ hardening of the arteries, ☐ chronic tiredness, ☐ nephritis, ☐ pyelitis.	
11T	Kidneys, ureters.	☐ skin conditions such as acne, ☐ pimples, ☐ eczema, ☐ or boils.	
12T	Small intestines, lymph circulation.	☐ rheumatism, ☐ gas pains, ☐ certain types of sterility.	
1L	Large intestines, inguinal rings.	☐ constipation, ☐ colitis, ☐ dysentery, ☐ diarrhea, ☐ some ruptures or hernias.	LOW BACK
2L	Appendix, abdomen, upper leg.	☐ cramps, ☐ difficult breathing, ☐ minor varicose veins.	
3L	Sex organs, uterus, bladder, knees.	☐ bladder troubles, ☐ menstrual troubles such as painful or irregular periods, ☐ miscarriages, ☐ bed wetting, ☐ impotency, ☐ change of life symptoms, ☐ many knee pains.	
4L	Prostate gland, muscles of the lower back, sciatic nerve.	☐ sciatica, ☐ lumbago, ☐ difficult, painful, or too frequent urination, ☐ backaches.	
5L	Lower legs, ankles, feet.	☐ poor circulation in the legs, ☐ swollen ankles, weak ankles and arches, ☐ cold feet, ☐ weakness in the legs, ☐ leg cramps.	
SACRUM	Hip bones, buttocks.	☐ sacro-iliac conditions, ☐ spinal curvatures.	PELVIS
COCCYX	Rectum, anus.	☐ hemorrhoids (piles), ☐ pruritis (itching), ☐ pain at end of spine on sitting.	

*Directly or indirectly controlled

For further explanation of the conditions shown above, and information about those not shown, ask your Doctor of Chiropractic.