Date: HR #:

CHIROPRACTIC

Chiropractic New Patient Paperwork

Name: _____ Birth Date: ____-____-____ Age: ____ Gender: _____
Address: _____ City: _____ State: _____ Zip Code: _____
SS Number: ____-____-____

Phone Number: _____ Home Cell Work Email: _____
Alternative Number: _____ Home Cell Work
May we text you
about your appointments? Please circle: Yes No

Marital Status: Please circle: Single Married Spouse Name: _____
Your Occupation: _____ Your Employer: _____

Emergency Contact: _____ Emergency Contact Phone Number: _____
Relationship to Emergency Contact: _____

History of Complaint

Please identify the condition(s)that brought you to this office? Please indicate side of involvement

1. _____
2. _____
3. _____
4. _____

On a scale of **0** to **10**, 0 being no pain and 10 being the worst pain, rate your complaints by circling the number:

1. No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain
2. No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain
3. No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain
4. No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain

When did the problem begin?

1. _____
2. _____
3. _____
4. _____

When is the problem at its worst? Circle one per line

1. AM Mid-day PM
2. AM Mid-day PM
3. AM Mid-day PM
4. AM Mid-day PM

How long does the pain last? Circle one per line

1. On and Off, Constant
2. On and Off, Constant
3. On and off, Constant
4. On and off, Constant

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How did the injury happen? Please indicate if any of the injuries are the result of **ANY** type of accident.

1._____

2._____

3._____

4._____

If anything, what makes your symptoms **better**? _____

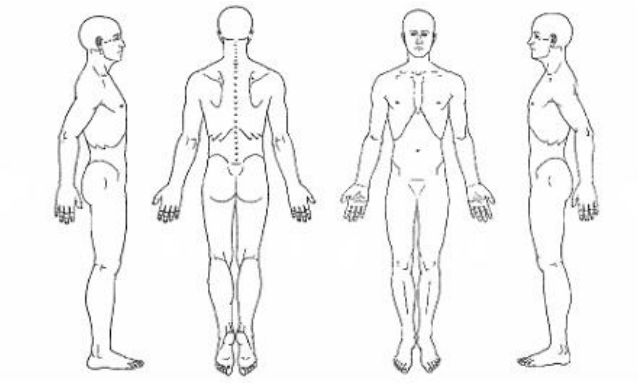
If anything, what makes your symptoms **worse**?_____

Have any of the above-mentioned conditions been treated by anyone in the past? Please circle: Yes or No

If **yes**, which conditions and by whom?_____
How long were you under care?_____
What were the results?_____

Have you ever seen a chiropractor before? Please circle: Yes No If **yes**, whom?_____

PLEASE MARK the areas on the body diagram with the following **letters** to describe your symptoms:
R=Radiating **B**=Burning **D**=Dull **A**=Aching **N**=Numbness **S**=Sharp/Stabbing **T**=Tingling



Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

_____

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Past History

Have you suffered with any of this or similar problem in the past? Please circle: Yes No

If **yes**, how many times?_____
When was the last episode?_____
How did that injury happen?_____
Any other forms of treatment tried: Yes or No If **yes**, please state what type of treatment?_____
Who provided the treatment?_____
How long ago?_____
What were the results? Favorable or Unfavorable
Please explain: _____

If you have had ever been diagnosed with **ANY** of the following conditions, please indicate on **each** line with:

P for in the Past **C** for Currently have **N** for Never have had

__ Broken Bone __Dislocation __Tumors __Rheumatoid Arthritis __Fracture

__Heart Attack __Osteo Arthritis __Diabetes __Stroke __Disability __Cancer

Please list any other serious conditions you have had or currently have:

_____

PLEASE IDENTIFY ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	How long ago?	Type of Care	Provided by Whom
Injuries:			
Surgeries:			
Childhood Diseases:			
Adult Diseases:			

_____ _____-_____-_____
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Family History

Does anyone in your family suffer from the same condition(s)? please circle: Yes No
If **yes**, whom (example: mom) and what condition?_____

Have they ever been treated for their condition(s)? Yes No Unsure

Are there any other hereditary conditions the doctor should be aware of? Yes No
If **yes**, which conditions?_____

Females Only

Are you currently pregnant? please circle: Yes No If **yes**, how many weeks?_____
Number of pregnancies? _____
Number of children and their ages? _____

Social History

Please circle:

1. **Smoking**: Cigars Pipe Cigarettes Vape
   How often? Daily Weekends Occasionally Former Never

2. **Alcoholic Beverages**: consumption occurs: Daily Weekends Occasionally Never

3. **Recreational Drug Use**: Daily Weekends Occasionally Former Never

Review of Systems

On each of the following lines, please indicate for **each** individual item:
P for **Past** **C** for **Current**

___Headache	___Pregnant (now)	___Dizziness	___Prostate problems	___Ulcers
___Neck Pain	___Frequent Colds/Flu	___Loss of Balance	___Impotence/Sexual Dysfunction	___Heartburn
___Jaw Pain/TMJD	___Convulsions/Epilepsy	___Fainting	___Digestive Problems	___Heart Problem
___Shoulder Pain	___Tremors	___Double Vision	___Colon Trouble	___High Blood Pressure
___Upper Back Pain	___Chest Pain	___Blurred Vision	___Diarrhea/Constipation	___Low Blood Pressure
___Mid Back Pain	___Pain w/ Cough/Sneeze	___Ringing in Ears	___Menopausal Problems	___Asthma
___Low Back Pain	___Foot or Knee Problems	___Hearing Loss	___Menstrual Problem	___Difficulty Breathing
___Hip Pain	___Sinus Drainage Problem	___Depression	___PMS	___Lung Problems
___Back Curvature	___Swollen/Painful Joints	___Irritable	___Bed wetting	___Kidney Trouble
___Scoliosis	___Skin Problems	___Mood Changes	___Learning Disability	___Gall Bladder Trouble
___Numb/Tingling arms, hands, fingers	___ADD/ADHD	___Eating Disorder	___Liver Trouble	
___Numb/Tingling legs, feet, toes	___Allergies	___Trouble Sleeping	___Hepatitis (A,B,C)	

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I hereby authorize payment to be made directly to Amazing Wellness and Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Amazing Wellness and Chiropractic for any and all services I receive at this office.

_____ _____-_____-_____

Patient or Authorized Person's Signature Date Completed

Financial Policy

Please take a few moments to review the following information prior to your appointment.

We hope you understand that our financial policies are established to assure the financial resources needed to maintain this chiropractic office for all our patients and the services that they need and want. We will work to ensure that your chiropractic care does not become a financial burden.

Charges for services are due and payable between you and your health insurance status. We accept cash, personal checks, and credit cards for payment on your account.

About Health Insurance

Your insurance policy is an agreement between you and your insurance company. Our relationship is with you, not your insurance company. Therefore, all charges are ultimately your responsibility, regardless of your insurance status.

Missed Appointment Policy

At Amazing Wellness and Chiropractic, we understand that life happens, however, due to necessity and appointment availability, we must respect all of our patient's time, as well as yours. Therefore, any appointment rescheduling must be done at least 24 hours prior to the scheduled appointment time.

If the patient fails to call and reschedule within the 24 hours of the scheduled appointment time and "no call no shows", a $20 missed appointment fee will be charged to the patient's account. The $20 missed appointment fee must be paid prior to any services being rendered.

I have read and understand the above policies.

_____ _____-_____-_____

Patient or Authorized Person's Signature Date Completed

_____ _____-_____-_____

Doctor's Signature Date Form Reviewed