*How did you hear about the office*_____

APPLICATION FOR CARE AT The New Health Chiropractic Center

Today's Date: _____ HRN: _____

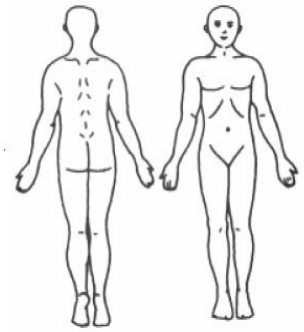
PATIENT DEMOGRAPHICS

Name: _____Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female
Address: _____ City: _____State: _____ Zip: _____
E-mail Address: _____Home Phone:_____Fax:_____
Mobile Phone: _____Work Phone: _____ Fax: _____
Social Security #: _____ Employer: _____
Occupation: _____ Name of Spouse: _____
Name & Number of Emergency Contact: _____Relationship: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____
Secondarily: _____ Third: _____
On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by c***ircling the number*:**
Primary or chief complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Second complaints is a: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Third complaint: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Name of Previous Chiropractor: _____ ☐ **N/A**

***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R = **R**adiating **B** = **B**urning **D** = **D**ull **A** = Aching **N** = **N**umbness **S** = **S**harp/ **S**tabbing **T**= **T**ingling



NUTRITION

Would you like to improve your nutrition? Y_____ N_____

Are you taking supplement or vitamins? Y_____ N_____

Please mark Y (Yes) or N (No) below on all symptoms you have ever had, even if they do not seem related to your problem.

___ Headache ___ Dizziness ___ Trouble Sleeping

___ Neck Pain ___ Frequent Colds/Flu ___ Loss of Balance ___ Impotence/Sexual Dysfun ___ Heartburn

___ Jaw Pain, TMJ ___ Convulsions/Epilepsy ___ Fainting ___ Digestive Problems ___ Diarrhea/Constipation

___ Shoulder Pain ___ Tremors ___ Blurred Vision ___ High Blood Pressure ___ Low Blood Pressure

___ Upper Back Pain___ Chest Pain ___ Ringing in Ears ___ Bed Wetting ___ Allergies

___ Mid Back Pain ___ Pain w/Cough/Sneeze ___ Hearing Loss ___ Menopausal Problems ___ Asthma

___ Low Back Pain ___ Foot or Knee Problems___ Depression ___ Menstrual Problem ___ Difficulty Breathing

___ Hip Pain ___ Sinus/Drainage Problem ___ Mood Swings ___ PMS ___ Ulcers

___ Scoliosis ___ Swollen/Painful Joints___ Numb/Tingling arms, hands, fingers ___ Numb/Tingling legs, feet, toes

List Prescription & Non-Prescription drugs you take:_____

_____

_____

FAMILY HEALTH HISTORY

Patient Name _____ Date _____

Please review the below listed symptoms and conditions and indicate those that are current health problems of a family member by the designation **C** under his or her column. The designation **P** should be used to indicate a past problem. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form.

	Father Age____	**Mother** Age____	**Spouse** Age____	**Brother**(s) Age____ Age____		**Sister**(s) Age____ Age____		**Children** Age____ Age____ Age____		
First Name										
Condition										
Allergies										
Anxiety										
Arthritis										
Auto Accidents										
Back Pain										
Cancer										
Constipation										
Diabetes										
Disc Problems										
Epilepsy										
Frequent Colds/Flus										
Gassy/Bloating										
Headache										
Heartburn										
Heart Trouble										
High Blood Pressure										
Low Energy										
Migraine										
Neck Pain										
Nervousness										
Pinched Nerve										
Scoliosis										
Sinus Trouble										
Sleeping Problems										
Other:										
Other:										
Other:										

The New Health Chiropractic Center

INFORMED CONSENT

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REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment Objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at The New Health Chiropractic Center have been explained to me to my satisfaction, and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

REGARDING: X-rays/Imaging Studies

☐ I have been provided a full explanation of when I am mostly likely to become pregnant, and to the best of my knowledge, **I am not pregnant**.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

MALES/FEMALES: By my signature below, I understand and give consent to be x-rayed if the doctor deems necessary.

REGARDING: Office Policies and HIPPA

This office conforms to the current HIPPA guidelines. You may request a copy of our HIPPA policy at the front desk.

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

_____ ____/____/____

Patient or Authorized Persons Signature *Date*