THE NEW HEALTH CHIROPRACTIC CENTER

The New Health Chiropractic Center
(925)-566-8881
1849 Willowpass Rd., Ste. 450
Concord, CA 94520

Patient Information:

Name:______________________________**DOB:**_______________**Date:**_________________

Address: ______________________________**City:** _________**State:** ______ **Zip:** ___________

Email: ____ **Phone:** _________________

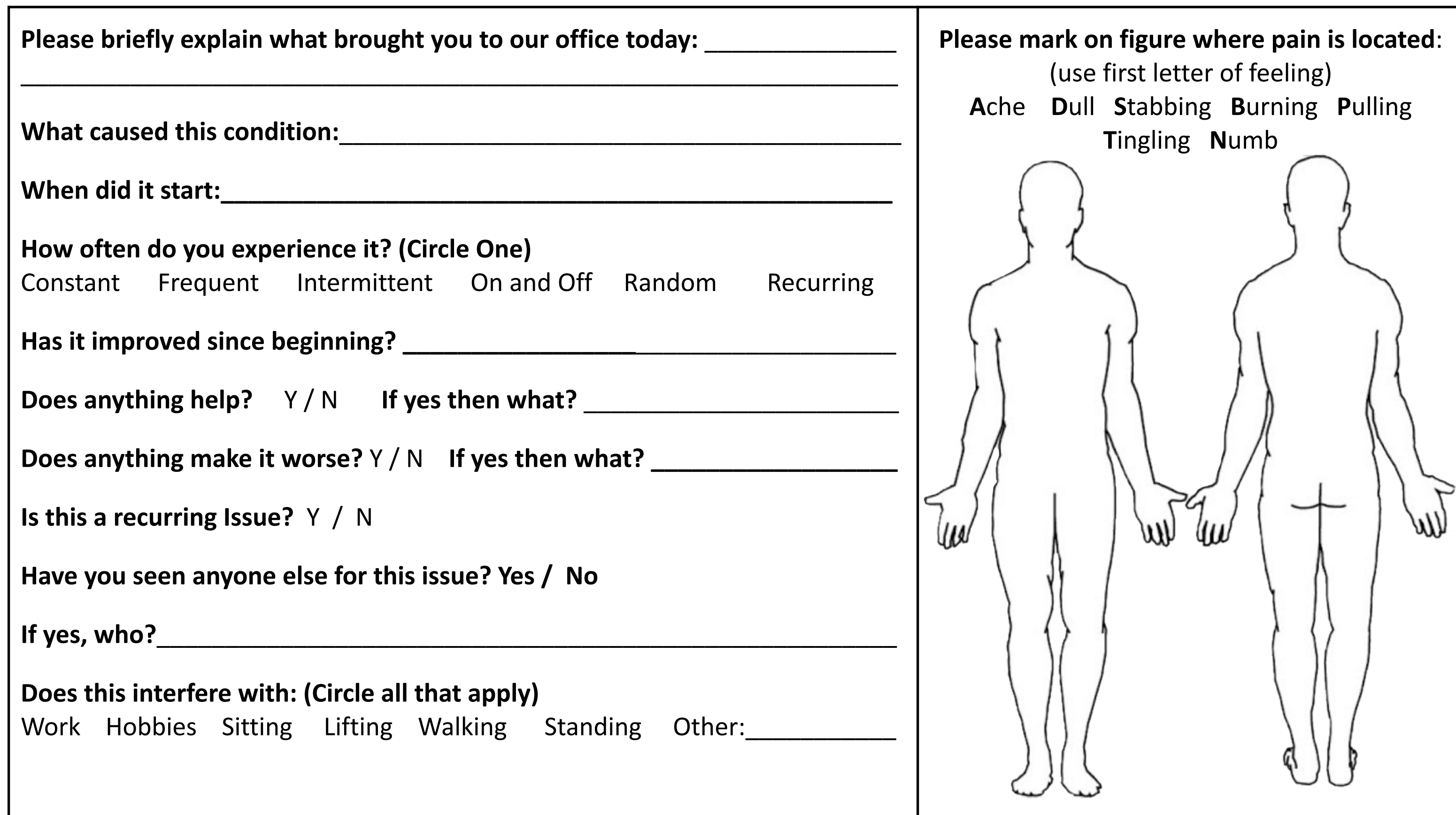
Occupation:_______________________ **Married Single Divorced Widowed Kids:** ______________

Emergency Contact:_______________________**Relationship:**____________ **Phone:**____________

Primary Care Physician:___________________ **Phone:**________________ **Location:**_____________

Specialist:______________________________**How did you hear about us:**_____________________

Symptoms:



Please briefly explain what brought you to our office today: ___________
____

What caused this condition:___________________________________

When did it start:_______________________________________

How often do you experience it? (Circle One)
Constant Frequent Intermittent On and Off Random Recurring

Has it improved since beginning? ______________________________

Does anything help? Y / N **If yes then what?** __________________

Does anything make it worse? Y / N **If yes then what?** ______________

Is this a recurring Issue? Y / N

Have you seen anyone else for this issue? Yes / No

If yes, who?____

Does this interfere with: (Circle all that apply)
Work Hobbies Sitting Lifting Walking Standing Other:_________

Please mark on figure where pain is located:
(use first letter of feeling)
Ache **D**ull **S**tabbing **B**urning **P**ulling
Tingling **N**umb

Please Check Any Conditions You May Have

Musculoskeletal:

[ ]Arthritis	[ ]Hip Disorders	[ ] Neck Pain	
[ ]Back Problems	[ ]Joint or Muscle Stiffness	[ ]Pins or Screws	[ ]No Known Conditions
[ ]Cramping	[ ]Knee Pain	[ ] Shoulder Problem	

Neurological:

[ ]Anxiety and/or Panic	[ ]Epilepsy or Seizures	[ ]Pins and Needles	
[ ]Depression	[ ]Headaches	[ ]Sleep Issues	[ ]No Known Conditions
[ ]Dizziness	[ ]Numbness	[ ]Stroke	

Head & E.N.T:

[ ]Blurred or Double Vision	[ ]Ear or Hearing Problems	[ ]Sinus Problems	
[ ]Eye or Vision Problems	[ ]Dental Problems	[ ]Headaches or Migraines	[ ]No Known Conditions

Cardiovascular:

[ ]Chest Pain or Tightness	[ ]Dizziness	[ ]High Cholesterol	
[ ]Congenital Heart-Defects	[ ]Heart Attacks	[ ]Low Blood Pressure	[ ]No Known Conditions
[ ]Coronary Artery Disease	[ ]Swollen Legs/Feet	[ ]High Blood Pressure	

Respiratory:

[ ] Apnea	[ ]Persistent Cough	[ ]Snoring	
[ ]Asthma	[ ]Pneumonia	[ ]Tuberculosis	[ ]No Known Conditions
[ ]Emphysema	[ ]Shortness of Breath	[ ]Wheezing	

Gastrointestinal:

[ ] Abdominal Pain	[ ]Colitis	[ ]Heartburn	
[ ]Bloating	[ ]Constipation	[ ]IBS	[ ]No Known Conditions
[ ]Changes in Bowel Movements	[ ]Food Sensitivities	[ ]Liver Disease	

Genitourinary:

[ ] Blood in Urine	[ ]Kidney Stones	[ ]Sexual Dysfunction	
[ ]Incontinence	[ ]Painful or Frequent Urination	[ ]Urinary Dysfunction	[ ]No Known Conditions

Endocrine:

[ ]Cushing's Syndrome	[ ]Hyperparathyroidism	[ ]Pancreatic Conditions	
[ ]Diabetes	[ ]Hyperthyroidism	[ ]Testosterone Deficiency	[ ]No Known Conditions
[ ]Heat or Cold Intolerance	[ ]Hypothyroidism	[ ]Thyroid Problems	

Derma/Hemo:

[ ]Change in Hair	[ ]Eczema	[ ]Hair Loss	
[ ]Easy Bruising	[ ]Acne	[ ]Psoriasis	[ ]No Known Conditions

Surgical History: Please list ALL previous surgery and the date on which it was performed:

____ _____________
____ _____________
____ _____________
____ _____________

Medications: *(please list all medications and supplements that you currently take)*

____________________________________ ____________________________________
____________________________________ ____________________________________
____________________________________ ____________________________________

Allergies: *(please list all medications that cause allergic reaction)*

____________________________________ ___________________________________
____________________________________ ___________________________________
____________________________________ ___________________________________

Social Habits:

Cigarettes: Y / N If yes, ______ packs per day for _____ years

Alcohol: Y / N If yes, number of drinks per week ________

Policies: (Please Initial all Boxes)

[ ] I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

[ ]I understand that The New Health Chiropractic Center will verify my insurance, but ultimately I am expected to understand my plan coverage. My insurance company will be billed as a courtesy to me. I will inform TNHCC of any insurance changes. THE BALANCE IS MY RESPONSIBILITY WHETHER MY INSURANCE PAYS OR NOT.

[ ] I acknowledge that I understand The New Health Chiropractic Center's Office Policies & Procedures and I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

[ ]I have given an explanation of when I am most likely to become pregnant, and to the best of my knowledge, **I am not pregnant.**

[ ]Appointment Cancellation Policy: To enhance appointment availability, anytime you are unable to keep your appointment, we ask that you notify us in advance. **If prior notification is not given, you will be charged a $15 cancellation fee.**

Signature: ____ Date: ____________________

Printed Name:____