

NEW PATIENT INFORMATION

Welcome to our office!
Please complete all questions.

Complete Wellness
CHIROPRACTIC
& Rehabilitation



Name: _____ Date: _____ Chart # _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Race: _____

Birthdate: _____ Age: _____ Social Security #: _____

Marital Status: Single Married Divorced Widow Primary Care Physician: _____

Your Employer: _____ Occupation: _____

Spouse's Name: _____ Spouse's Employer: _____

Children's Names and Ages: _____

Favorite Hobbies or Interests: _____

Method of Payment or Insurance Carrier: _____

Policy Holder/Guarantor Information (If other than self)

Name: _____

Address: _____

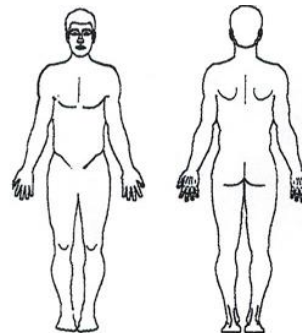
City, State, Zip: _____

Phone Number: _____

Birth Date: _____

Social Security #: _____

Mark an X on the picture where you
have pain or other symptoms.



Describe your current problem and how it began: (circle one)

Headache Neck Pain Mid-Back Pain Low Back Pain Other _____

Have you had same or similar problem(s) before? _____ If so for how long? _____

Family members (immediate family) with similar problems? _____

Is this? Work Related Auto Related N/A

Date problem began: _____

How problem began: _____

Other doctors you have seen for this problem? _____

Current complaint (how you feel today):										
0	1	2	3	4	5	6	7	8	9	10
No Pain									Unbearable Pain	

How often are your symptoms present? (Please circle one)

(Occasional) 0-25% 26-50% 51-75% 76-100% (Constant)

In general would you say your overall health right now is:

Excellent

Very Good

Good

Fair

Poor

Have you had spinal X-Rays, MRI, CT Scan for your area(s) of complaint?

NO

YES

Date(s) taken: _____

What areas were taken? _____

Please circle all of the following that apply to you:

Alcohol/Drug Dependence

Recent Fever

Diabetes

High Blood Pressure

Stroke (Date) _____

Corticosteroid Use (Cortisone, Prednisone, etc.)

Taking Birth Control Pills

Dizziness/Fainting

Numbness in Groin/Buttocks

Cancer/Tumor (explain) _____

Osteoporosis

Epilepsy/Seizures

Other Health Problems (explain) _____

Prostate Problems

Menstrual Problems

Urinary Problems

Currently Pregnant, # weeks _____

Abnormal Weight Gain/Loss

Marked Morning Pain/Stiffness

Pain Unrelieved by position or Rest

Pain at Night

Visual Disturbances

Surgeries _____

Tobacco Use-Type _____

Frequency _____/Day

Medications _____

Family History (circle any that apply)

Cancer

Diabetes

High Blood Pressure

Heart Problems/Stroke

Rheumatoid Arthritis

Who may we thank for referring you? _____

Circle how you would like appointment reminders:

Phone

Text

Email

Cell Phone Carrier (for text reminders only) _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at Complete Wellness Chiropractic and Rehabilitation, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient or Guardian Signature: _____

Date: _____