

New Patient Information

| | | | |
|--|-----------------------|---|---------------------------|
| First Name _____ | MI _____ | Last Name _____ | Date _____ |
| Address _____ | | City _____ | Zip _____ |
| Home Phone () _____ | Work Phone () _____ | Cell Phone () _____ | |
| Email Address _____ | | Date of Birth _____ | Age _____ |
| Marital Status <u>M S W D</u> | No. of Children _____ | Pregnant <u>Y N</u> | Height _____ Weight _____ |
| Social Security # _____ | | Occupation/Employer _____ | |
| Name of Spouse _____ | | Name of Guardian (if minor) _____ | |
| Spouse's Occupation _____ | | Name of party responsible for payment _____ | |
| Does your insurance company contribute to chiropractic care? Y N | | | |
| Name of Insurance _____ | | Member ID _____ | |
| Address _____ | | Phone () _____ | |
| WHO MAY WE THANK FOR REFERRING YOU TO US? _____ | | | |

| | | | |
|--|-------|--|--|
| List your conditions (in order of priority) that nerve interference may be contributing. | | | |
| 1. | _____ | | |
| 2. | _____ | | |
| 3. | _____ | | |
| 4. | _____ | | |
| Are these conditions interfering with: (circle all that apply) work sleep exercise routine | | | |
| Are you taking any medications (drugs)? Y N If yes, which drugs? _____ | | | |
| _____ | | | |

| | |
|---|--|
| List any auto or work related injuries and/or accidents and when they occurred. | |
| _____ | |
| _____ | |
| _____ | |
| List any surgeries and when you had them performed. | |
| _____ | |
| _____ | |
| _____ | |

| | | | | | |
|-----------------------|---|---|---|---|---|
| Do you smoke? | Y | N | Do you participate in extreme activities? | Y | N |
| Do you drink alcohol? | Y | N | Do you wear orthotics? | Y | N |
| Do you take vitamins? | Y | N | | | |

| | | | |
|--|---|---|--|
| Do you exercise? | Y | N | If so, please describe your exercise routine _____ |
| _____ | | | |
| _____ | | | |
| Briefly describe your nutritional habits (i.e.-typical breakfast, lunch, dinner, and snacks) | | | |
| _____ | | | |
| _____ | | | |
| _____ | | | |

New Patient Information

Circle the following conditions that you suffer from or have suffered from in the past.

| | | | | |
|------------------|-----------------|-----------------|------------------|-----------------|
| Allergies | Alcoholism | Anemia | Arthritis | Asthma |
| Cancer | Seizures | Constipation | Cold Sores | Diabetes |
| Sinus Problems | Diarrhea | Eczema | Emphysema | Gall Bladder |
| Gout | High Blood Pr. | Heart Disease | Menstrual Cramps | Irreg. Periods |
| Hot Flashes | Migraines | Light Sensitive | Fatigue | Irritability |
| Heartburn | Miscarriage | Mult. Sclerosis | Neuritis | Nervousness |
| Depression | Pneumonia | Polio | Headaches | Ringing in Ears |
| Dizziness | Loss of Balance | Stroke | Heart Attack | Tuberculosis |
| Thyroid Problems | Ulcers | Whooping Cough | Low Blood Sugar | Neck Pain |
| Numbness(arms) | Back Pain | Numbness(legs) | Mood Swings | Upset Stomach |
| Fibromyalgia | Sleep Problems | Shoulder Pain | Elbow/wrist Pain | Knee Pain |
| Ankle/foot Pain | | | | |

I understand and agree that the health and accident insurance policies are an arrangement between me and my insurance carrier. Furthermore, I understand that Finnell Chiropractic Group may prepare any necessary reports to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Finnell Chiropractic Group will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature

Date

Guardian's Signature

Date