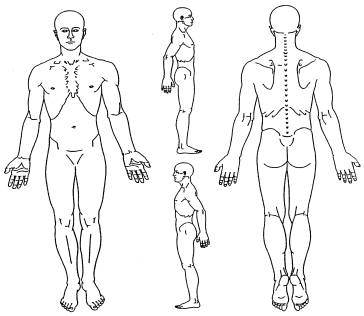
Welcome To New Life Chiropractic

Who may we thank for referring you to our office or how did you find us? _____
Have you ever been under chiropractic care before? ❑No ❑Yes. If yes, For what?: _____

PATIENT DATA (Please Print Legibly):

Name _____ Email _____
For general office announcements and promotions ONLY.
Address _____ City _____ State _____ Zip _____
Phone (Cell) _____ (Home) _____
Age _____ Birth Date _____ Sex ❑M ❑F Occupation _____ Hrs worked per week _____
Emergency Contact _____ Relationship _____Phone _____

PRIMARY COMPLAINT: Your PRIMARY complaint is located where? Circle the area below.

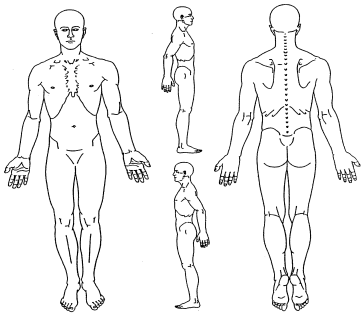


1. When did your symptom first appear? _____
2. What caused this or how did you do it? _____
3. Explain if you felt this symptom before? _____
4. What activity makes this symptom feel worse? _____
5. What do you do to make this feel better? _____
6. Type of pain or discomfort: ❑Sharp ❑Dull ❑Ache ❑Numbness ❑Shooting ❑Tight ❑Burning ❑Tingling ❑Swelling ❑Stabbing ❑Itching ❑Throbbing ❑Other _____
7. Overall Frequency of complaint: ❑Constant 100% of the time ❑Frequent 75% ❑Intermittent-50% ❑Occasional-25%
8. *Circle the severity of your pain at its LOWEST and at its HIGHEST. Use the scale of Zero (no pain) to 10 (severe pain).*

|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
0 1 2 3 4 5 6 7 8 9 10

9. Does this symptom affect you at: *Sleep* ___ *Work* ___ *Play/Hobby/Sport* ___ Driving ___ Sitting ___ Standing ___

SECOND COMPLAINT: Your SECOND complaint is located where? Circle the area below.



1. When did your symptom first appear? _____
2. What caused this or how did you do it? _____
3. Explain if you felt this symptom before? _____
4. What activity makes this symptom feel worse? _____
5. What do you do to make this feel better? _____
6. Type of pain or discomfort: ❑Sharp ❑Dull ❑Ache ❑Numbness ❑Shooting ❑Tight ❑Burning ❑Tingling ❑Swelling ❑Stabbing ❑Itching ❑Throbbing ❑Other _____
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|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
0 1 2 3 4 5 6 7 8 9 10

9. Does this symptom affect you at: *Sleep* ___ *Work* ___ *Play/Hobby/Sport* ___ Driving ___ Sitting ___ Standing ___

FOR WOMEN:

Is there a chance you are Pregnant? ❑No ❑Yes ❑ Not sure! How many weeks? _____
Are you nursing? ❑No ❑Yes
Do you have breast implants? ❑No ❑Yes

Print Name (again please): _____ **Date of Birth (again please):** _____

Stated Height: _____ **Stated Weight:** _____

HEALTH HISTORY: Please check each of the conditions that you **have now or had in the past**

- ❑AIDS / HIV
- ❑Allergies
- ❑Arm Pain/Tingling
- ❑Asthma
- ❑Cancer
- ❑Constipation
- ❑Depression
- ❑Diabetes
- ❑Digestive Problems
- ❑Dizziness / Vertigo
- ❑Epilepsy
- ❑Feet Pain/Tingling
- ❑Hand Pain/Tingling
- ❑Headaches
- ❑Heart Attack/Stroke
- ❑High/Low Blood Pressure
- ❑Herniated Disk
- ❑Irritable Bowel
- ❑Jaw Pain
- ❑Loss of Sleep
- ❑Lower Back Problems
- ❑Mid Back Problems
- ❑Migraines
- ❑Multiple Sclerosis
- ❑Neck Pain
- ❑Numbness _____
- ❑Parkinson's Disease
- ❑Sciatica
- ❑Shoulder Pain/Tingling
- ❑Stroke
- ❑Tumors/Growths
- ❑Pain that wakes you up at night
- ❑ Other _____

Injuries/Surgeries you have had: **Description** **Date**

Significant Falls _____ _____

Head Injuries _____ _____

Broken Bones/Dislocations _____ _____

Surgeries _____ _____

Have you ever been in a motor vehicle accident before: Past Year ___, Past 5 Years ___ , Over 5 Years ___ ,Never ___

Have you ever done the following: Skydive ___, Gymnastics ___, Contact Sports ___, Horse Riding ___, Ski (snow/water) ___

Lifestyle Habits:

Tobacco (#/day) _____ Coffee (cups/day) _____ Sleep (hrs/day) _____ Water (oz/day) _____

Alcohol (drinks/day) _____ Tea (cups/day) _____ Soft Drinks (cans/day) _____ ❑Diet or ❑Regular

Exercise: Type _____ Frequency _____

Where in your body do you feel your stress: Shoulders ___ Low Back ___ Head/Neck ___

FAMILY HISTORY: Please tell us about the major health conditions of your immediate family.

Family Member Relation:	**Health Problem:**
_____	_____
_____	_____

MEDICATIONS TAKEN NOW: List prescription, OTC, vitamins, minerals, herbs & supplements etc.

Name:	**Purpose:**	**How Long Taken?:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

FINANCIAL AGREEMENT:

I understand and agree that health/accident insurance policies are an arrangement between me and my insurance carrier. I hereby authorize assignment/payment of my insurance rights and benefits (if applicable) directly to New Life Chiropractic for services rendered. There may be instances where New Life Chiropractic will provide me with a 'Statement of Charges' that I can personally send directly to my insurance company for reimbursement back to me. **I clearly understand and agree that all services rendered to me are charged directly to me and that I am ultimately personally and financially responsible for payment to New Life Chiropractic whether or not paid by insurance. All payment is due at the time of service.**

_____

Patient (or Guardian) Signature Date of 1st Visit