NEW PATIENT PROFILE

PERSONAL

Last Name _____ First Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Alternate Phone _____ Email _____

Social Security # _____ Driver's Lic # _____ State Where Issued _____

Age _____ Birthdate _____ Sex _____ Married ☐ Single ☐ Widowed ☐ Divorced ☐ No of Children _____

Occupation _____ Employer _____ Years Employed _____

Employer's Address _____ City _____ State _____ Zip _____

Spouse or Partner's Name _____ Occupation _____ Employer _____

Person responsible for this account? _____ Referred by _____

CONDITION

What is your major complaint? _____

Other complaints? _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? ☐ Yes ☐ No

What activities aggravate your condition? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unsure ☐ Constant ☐ Comes and goes

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine ☐ Other

How long has it been since you really felt good? _____

List surgical operations: _____

Are you taking any medications? ☐ Yes ☐ No If so, what kind? _____

Are you taking any non-prescription drugs? ☐ Yes ☐ No If so, what kind? _____

OTHER DOCTORS SEEN FOR THIS CONDITION: ☐ MD ☐ DC ☐ DO ☐ DDS

Doctor's Name _____ Diagnosis _____

Are X-rays available? ☐ Yes ☐ No ☐ Urinalysis? ☐ Yes ☐ No ☐ Blood Tests? ☐ Yes ☐ No ☐ Other

Treatment: Medication _____ Physiotherapy _____

Results _____ Length of time under care _____

Were you off of work? ☐ Yes ☐ No ☐ If so, how long? Have you returned to same job? ☐ Yes ☐ No

How often do you experience your symptoms?

- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

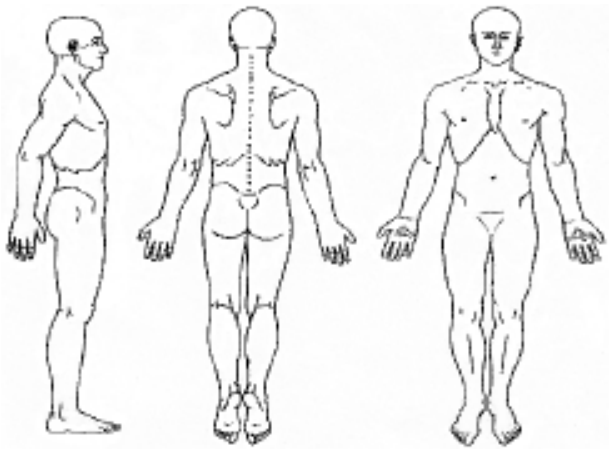
What describes the nature of your symptoms?

☐ Sharp ☐ Shooting ☐ Dull Ache ☐ Burning ☐ Numb ☐ Tingling

During the past 4 weeks, indicate the average intensity of your symptoms:

None Unbearable

1 2 3 4 5 6 7 8 9 10



Indicate above where you have pain or other symptoms

CONDITION - CONT'D

IMPORTANT: Please check all present symptoms

HEAD
- Headache
  - sinus (allergy)
  - entire head
  - back of head
  - forehead
  - temples
  - migraine
- Head feels heavy
- Lose of memory
- Light-headedness
- Fainting
- Light bothers eyes
- Blurred vision
- Double vision
- Loss of vision
- Loss of taste
- Loss of balance
- Dizziness
- Loss of hearing
- Pain in ears
- Ringing in ears
- Buzzing in ears

NECK
- Pain in neck
- Neck pain with movement
  - Forward
  - Backward
  - Turn to left
  - Turn to right
  - Bend to left
  - Bend to right
- Pinched nerve in neck
- Neck feels out of place
- Muscle spasms in neck
- Grinding sounds in neck
- Popping sounds in neck
- Arthritis in neck

SHOULDERS
- Pain in right shoulder joint
- Pain in left shoulder joint
- Pain across shoulders
- Bursitis (right)
- Bursitis (left)
- Arthritis (right)
- Arthritis (left)
- Can't raise arm:
  - above shoulder level
  - over head
- Tension in shoulders
- Pinched nerve in right shoulder
- Pinched nerve in left shoulder
- Muscle spasms in shoulders

ARMS & HANDS
- Pain in upper arms
- Pain in elbows
- Movement aggravated
- Tennis elbow
- Pain in forearms
- Pain in hands
- Pain in fingers
- Sensation of pins & needles in arms
- Sensation of pins & needles in fingers
- Numbness in right arm
- Numbness in left arm
- Numbness in fingers (right)
- Numbness in fingers (left)
- Fingers go to sleep
- Hands cold
- Swollen joints in fingers
- Sore joints in fingers
- Arthritis in fingers
- Loss of grip strength

MID-BACK
- Mid-back pain
- Location _____
- Pain between shoulder blades
- Sharp stabbing
- Dull ache
- Pain from front to back
- Muscle spasms
- Pain in kidney area

CHEST
- Chest pain
- Shortness of breath
- Pain around ribs
- Breast pain
- Dimpled or orange peel breast
- Irregular heartbeat

ABDOMEN
- Nervous stomach
- Foods you can't eat:

- Nausea
- Gas
- Constipation
- Diarrhea
- Hemorrhoids

LOW BACK
- Low back pain
  - Upper lumbar
  - Lower lumbar
  - Sacroilliac
- Low back pain is worse when:
  - working
  - lifting
  - stooping
  - standing
  - sitting
  - bending
  - coughing
  - lying down (sleeping)
  - walking
- Pain relieves when

- Slipped disk
- Low back feels out of place
- Muscle spasms
- Arthritis

HIPS, LEGS & FEET
- Pain in buttocks (right side)
- Pain in buttocks (left side)
- Pain down right leg
- Pain down left leg
- Knee pain:
  - inside
  - outside
- Leg cramps
- Cramps in right foot
- Cramps in left foot
- Pins & needles in right leg
- Pins & needles in left leg
- Numbness in right leg
- Numbness in left leg
- Numbness in right foot
- Numbness in left foot
- Numbness in toes (right foot)
- Numbness in toes (left foot)
- Feet feel cold
- Swollen ankle (right leg)
- Swollen ankle (left leg)

WOMEN ONLY
- Menstrual pain
  - Where?
- Cramping
- Irregularity
- Cycle_____days
- Birth control
  - Type?
- Hysterectomy
- Genital cancer
- Discharge
- Menopause
- Tumors
- Abortions
- Are you or do you think you are pregnant?

MEN ONLY
- Urinary frequency
- Difficulty in starting
- Night urination
- Prostate pain/swelling

GENERAL
- Nervousness
- Irritable
- Depressed
- Fatigued
- Generally feel run-down
- Normal sleep (in hours)_____
- Loss of sleep (in hours/night)_____
- Loss of weight_____ lbs.
- Weight gain_____ lbs.
- Coffee (cups per day)_____
- Tea (cups per day)_____
- Cigarettes (packs per day)_____
- Other
- Diabetes
- Hypoglycemia

REMARKS

Please use the space below to share any additional symptoms, concerns or thoughts:

INSURANCE

Are you covered by Medicare? ☐ Yes ☐ No If so, Medicare # _____ State Insurance Aid? ☐ Yes ☐ No

Do you have any group, union or personal health and accident insurance? ☐ Yes ☐ No

Name of Insurance Company _____ Claim Number _____ Group Number _____

Address _____ Phone _____ Agent Name _____

Additional Insurance Company _____ Claim Number _____ Group Number _____

Address _____ Phone _____ Agent Name _____

Is your condition due to an accident? ☐ Yes ☐ No Is your condition due to an illness? ☐ Yes ☐ No ☐ Other

ACCIDENT

Did your accident occur while on the job? ☐ Yes ☐ No Were you involved in an auto accident? ☐ Yes ☐ No

Date _____ Time _____ Injury reported to employer? ☐ Yes ☐ No Supervisor _____

Description of accident: _____

_____

Were you injured? ☐ Yes ☐ No If so, how?

Location of accident _____

Were you unconscious? ☐ Yes ☐ No Fractures? ☐ Yes ☐ No Cuts? ☐ Yes ☐ No Bruises? ☐ Yes ☐ No

Were you taken to a hospital? ☐ Yes ☐ No If so, which one? _____ Treatment _____

Confined to hospital for _____ days _____ hours Name of attending physician _____

Have you had any other personal injury or accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ None

Describe this accident: _____

Do you have an attorney? ☐ Yes ☐ No If so, name _____

Address _____ Phone _____ Email _____

COMPLEMENTARY THERAPIES

Are you interested in learning more about ☐ Nutrition ☐ Weight Loss ☐ Body Detoxification

Are you interested in learning more about ☐ Massage Therapy ☐ Orthopaedic ☐ Ultra-Sound Therapy

AGREEMENT

I, the undersigned, clearly understand and agree that all services rendered to 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 and treatment, any fees for professional services rendered to me will be immediately due and payable.

_____

Patient (print)

_____ _____

Patient signature Date

AUTHORIZATION & RELEASE

SIGNATURE ON FILE

I, the undersigned, hereby authorize the following:

1. Use of this form on all insurance submissions;
2. Release of my medical and chiropractic information to my insurance company(ies);
3. My chiropractor to act as my agent in helping me obtain payment from my insurance company(ies);
4. Payment direct to my chiropractor.

In addition to the above, I permit a copy of this authorization to be used in place of the original and understand that I am responsible for payment of all bills relating to treatment administered by Active Chiro Center.

Patient (print)

Social Security No.

Patient signature

Date