

# CORRECTIVE CHIROPRACTIC

WELCOME TO OUR OFFICE  
(Confidential Patient Health Record)

Date:

I.D No.

## NEW PATIENT APPLICATION

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State/Prov: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M  F   
Cell Phone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
Employer: \_\_\_\_\_ Employer Phone Number: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Referred to Office by: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Primary Insurance: \_\_\_\_\_ Policy/Group Number: \_\_\_\_\_  
Secondary Insurance: \_\_\_\_\_ Policy/Group Number: \_\_\_\_\_  
Responsible Party: Self  Spouse  Worker's Comp  Auto Ins.  Medicare  Medicaid   
Primary Care Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Name of Spouse: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_  
Spouse's Occupation: \_\_\_\_\_ Employer Phone Number: \_\_\_\_\_

*Please help us to get to know you better, as well as identifying other areas of your life that may  
be contributing to your health status.*

Marital Status: Single  Married  Divorced  Separated  Widowed

Children/Ages: \_\_\_\_\_

### **Recreation**

Hobbies: \_\_\_\_\_

Exercise done on a regular basis: \_\_\_\_\_

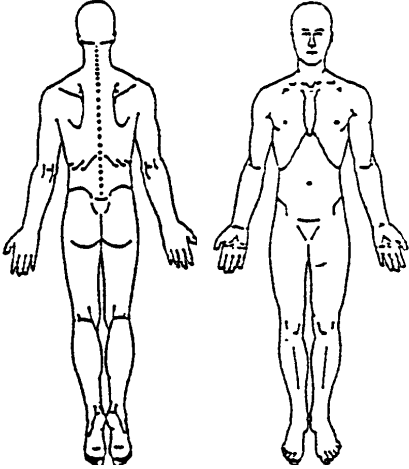
Free Time: I am sedentary \_\_\_\_\_ % I am physically active \_\_\_\_\_ %

### **Employment**

Please Rate the Following:

Work at computer	_____ %	Sit	_____ %
Travel in the car	_____ %	Stand	_____ %
On Phone	_____ %	Walk	_____ %

**CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:**

<p><b>Musculo-Skeletal Code</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Low Back Pain</li> <li><input type="checkbox"/> Pain Between Shoulders</li> <li><input type="checkbox"/> Neck Pain</li> <li><input type="checkbox"/> Arm Pain</li> <li><input type="checkbox"/> Joint Pain/Stiffness</li> <li><input type="checkbox"/> Walking Problems</li> <li><input type="checkbox"/> Difficult Chewing/Clicking Jaw</li> <li><input type="checkbox"/> General Stiffness</li> </ul> <p><b>Nervous System Code</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Nervous</li> <li><input type="checkbox"/> Numbness</li> <li><input type="checkbox"/> Paralysis</li> <li><input type="checkbox"/> Dizziness</li> <li><input type="checkbox"/> Forgetfulness</li> <li><input type="checkbox"/> Confusion/Depression</li> <li><input type="checkbox"/> Fainting</li> <li><input type="checkbox"/> Convulsions</li> <li><input type="checkbox"/> Cold/Tingling Extremities</li> <li><input type="checkbox"/> Stress</li> </ul> <p><b>General Code</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Fatigue</li> <li><input type="checkbox"/> Allergies</li> <li><input type="checkbox"/> Loss of Sleep</li> <li><input type="checkbox"/> Fever</li> <li><input type="checkbox"/> Headaches</li> </ul> <p><b>Gastro-Intestinal Code</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Poor/Excessive Appetite</li> <li><input type="checkbox"/> Excessive Thirst</li> <li><input type="checkbox"/> Frequent Nausea</li> <li><input type="checkbox"/> Vomiting</li> <li><input type="checkbox"/> Diarrhea</li> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Hemorrhoids</li> <li><input type="checkbox"/> Liver Problems</li> <li><input type="checkbox"/> Gall Bladder Problems</li> <li><input type="checkbox"/> Weight Trouble</li> <li><input type="checkbox"/> Abdominal Cramps</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Gas/Bloating After Meals</li> <li><input type="checkbox"/> Heartburn</li> <li><input type="checkbox"/> Black/Bloody Stool</li> <li><input type="checkbox"/> Colitis</li> </ul> <p><b>Genito-Urinary Code</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Bladder Trouble</li> <li><input type="checkbox"/> Painful/Excessive Urination</li> <li><input type="checkbox"/> Discolored Urine</li> </ul> <p><b>C-V-R Code</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chest Pain</li> <li><input type="checkbox"/> Short Breath</li> <li><input type="checkbox"/> Blood Pressure Problems</li> <li><input type="checkbox"/> Irregular Heartbeat</li> <li><input type="checkbox"/> Heart Problems</li> <li><input type="checkbox"/> Lung Problems/Congestion</li> <li><input type="checkbox"/> Varicose Veins</li> <li><input type="checkbox"/> Ankle Swelling</li> <li><input type="checkbox"/> Stroke</li> </ul> <p><b>EENT Code</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Vision Problems</li> <li><input type="checkbox"/> Dental Problems</li> <li><input type="checkbox"/> Sore Throat</li> <li><input type="checkbox"/> Ear Aches</li> <li><input type="checkbox"/> Hearing Difficulty</li> <li><input type="checkbox"/> Stuffed Nose</li> </ul> <p><b>Male/Female Codes</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Menstrual Irregularity</li> <li><input type="checkbox"/> Menstrual Cramps</li> <li><input type="checkbox"/> Vaginal Pain/Infection</li> <li><input type="checkbox"/> Breast Pain/Lumps</li> <li><input type="checkbox"/> Prostate/Sexual Dysfunction</li> <li><input type="checkbox"/> Other Problems</li> <li><input type="checkbox"/> _____</li> <li><input type="checkbox"/> _____</li> <li><input type="checkbox"/> _____</li> <li><input type="checkbox"/> _____</li> </ul>	<p>Females Only: When was your last period? _____</p> <p>Are you pregnant? <input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Not Sure</p> <div style="text-align: center;">  </div> <p>Please show on the diagram above your areas of discomfort.</p> <p><b>FAMILY HISTORY</b> The following members have the same or similar problem as I do:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Mother</li> <li><input type="checkbox"/> Father</li> <li><input type="checkbox"/> Brother</li> <li><input type="checkbox"/> Sister</li> <li><input type="checkbox"/> Spouse</li> <li><input type="checkbox"/> Child</li> </ul>
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I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I 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, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through use of manipulation throughout my spine. It is understood and agreed the amount paid the Doctor, is for examination and X-rays only. The X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_