PERSONAL INFO

DATE

FIRST NAME | LAST NAME

DATE OF BIRTH | AGE | SEX O M O F | SSN #

ADDRESS | CITY | STATE | ZIP

EMAIL ADDRESS

PHONE | ALT. PHONE

WHICH COMMUNICATION DO YOU PREFER FOR APPOINTMENT REMINDERS?
O E-MAIL OTEXT MESSAGE (CARRIER _____________) O PHONE CALL

OCCUPATION | EMPLOYER

MARITAL STATUS O SINGLE O MARRIED O DIVORCED O WIDOWED # OF CHILDREN

SPOUSE/EMERGENCY CONTACT | PHONE

INSURANCE COMPANY | MEMBER ID#

PHONE NO. | GROUP #

POLICY HOLDER NAME | RELATION TO YOU

CURRENT COMPLAINTS

REASON FOR YOUR VISIT TODAY

HOW DOES THIS AFFECT YOUR DAILY ACTIVITIES?

DATE OF INJURY | DATE SYMPTOMS APPEARED

HAVE YOU EVER HAD THE SAME CONDITION? O N O Y | IF YES, WHEN?

LIST OTHER PRACTITIONERS SEEN FOR THIS COMPLAINT

HAVE YOU EVER BEEN UNDER CHIROPRACTIC CARE? ON OY | IF YES, WHEN?

IF YOU HAVE PAIN, IS IT? O SHARP O DULL O CONSTANT O INTERMITTENT O TRAVELING
O RADIATING O MILD O MODERATE O SEVERE O INTOLERABLE

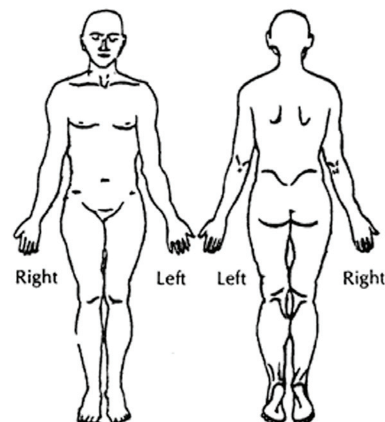
PLEASE RATE HOW YOU FEEL TODAY:

0 1 2 3 4 5 6 7 8 9 10

NO PAIN UNBEARABLE PAIN

RIGHT: PLEASE INDICATE THE LOCATION OF THE SYMPTOMS YOU ARE CURRENTLY EXPERIENCING

WHAT DOES IT FEEL LIKE? HOW OFTEN IS IT PRESENT?



SYMPTOMS/CONDITIONS

- ○ ALLERGIES/SINUS PROBLEMS
- ○ BREATHING PROBLEMS/ASTHMA
- ○ HEADACHES/MIGRAINES
- ○ SKIN PROBLEMS

- ○ LOSS OF SMELL/TASTE
- ○ LOSS OF MEMORY
- ○ LOSS OF BALANCE
- ○ EYE/VISION TROUBLE
- ○ DIZZINESS
- ○ RINGING OF EARS/EARACHES

- ○ HERNIATED DISC
- ○ SPINAL SURGERY

- ○ STOMACH UPSET/HEARTBURN
- ○ DIARRHEA/CONSTIPATION/GAS
- ○ DIABETES
- ○ KIDNEY PROBLEMS
- ○ ULCERS
- ○ RECENT WEIGHT LOSS/GAIN
- ○ HIGH/LOW BLOOD PRESSURE
- ○ HIGH CHOLESTEROL
- ○ HEART DISEASE
- ○ THYROID DISORDER
- ○ COLD HANDS/FEET
- ○ FATIGUE
- ○ LOSS OF MEMORY
- ○ SLEEP APNEA
- ○ DEPRESSION/ANXIETY

- ○ SWOLLEN JOINTS
- ○ ARTHRITIS
- ○ CHEST PAINS
- ○ INFECTIONS
- ○ NUMBNESS IN LEGS
- ○ NUMBNESS IN ARMS

- ○ MISCARRIAGE
- ○ PAINFUL/IRREG. MENSTRUATION
- ○ HOT FLASHES
- ○ COLD SWEATS

- ○ CANCER
PLEASE DESCRIBE. ______________________

MEDICAL HISTORY

HAVE YOU BEEN TREATED FOR ANY CONDITIONS IN THE LAST YEAR? ○ N ○ Y
IF YES, PLEASE DESCRIBE

DATE OF LAST PHYSICAL EXAM

HAVE YOU HAD X-RAYS TAKEN? ○ N ○ Y

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? (INCLUDE DOSAGE & FREQUENCY)

WHAT VITAMINS, MINERALS OR HERBS ARE YOU CURRENTLY TAKING? (DOSAGE & FREQUENCY)

ARE YOU OR COULD YOU BE PREGNANT? ○ N ○ Y

ARE YOU NURSING? ○ N ○ Y

FOR PREGNANT PATIENTS ONLY
OF WEEKS

ESTIMATED DUE DATE

BIRTH PROVIDER

GOALS FOR LABOR/DELIVERY (LOCATION, WHO WILL BE THERE, ATMOSPHERE, ETC.)

COMPLICATIONS/SYMPTOMS RELATED TO THIS PREGNANCY

PREVIOUS PREGNANCY/LABOR/DELIVERY COMPLICATIONS

HABITS

	NONE	LIGHT	MED.	HEAVY
ALCOHOL	○	○	○	○
CAFFEINE	○	○	○	○
TOBACCO	○	○	○	○
DRUGS	○	○	○	○
EXERCISE	○	○	○	○
WATER	○	○	○	○
FRUITS/VEGGIES	○	○	○	○

I verify that all this information is accurate and correct. I understand that verification and authorization of insurance is not a guarantee of payment. I understand that I am responsible for any balance not paid by insurance. I authorize New Directions Chiropractic, PLLC to release any information regarding my treatment to any insurance carrier in effort to receive reimbursement for services provided. I authorize the use of this signature on all submissions.

PRINTED NAME

SIGNATURE