Equ.S.T. CHIROPRACTIC

New Patient Forms

Patient Information

Today's Date_____/_____/_____

Patient Name

_____
First Middle Initial Last

Sex [ ] M [ ] F

Birthdate_____ Age_____

Address_____

City _____State _____Zip_____
[ ] Married [ ] Widowed [ ] Single
[ ] Divorced [ ] Separated [ ] Other

Contact Information

Phone_____ [ ]Mobile [ ]Home [ ]Work

Phone_____ [ ]Mobile [ ]Home [ ]Work

Email_____

Occupation _____

Business Name _____

Spouse's Name _____

Spouse's Birthdate _____

Whom may we thank for referring you?

_____

In Case of Emergency

Name_____

Relationship_____

Phone_____

Updated 07/18/2023

No insurance accepted. You can request a detailed statement and submit for potential reimbursement on your own.

**Payment for services is at the time of service with cash, check, or credit card. No invoices are sent. **

NO WORKMANS COMP, AUTO ACCIDENT AND PERSONAL INJURY CLAIMS

**If this is the result of an accident, please let the doctor know immediately. She can refer you to another chiropractor.
Thank you

Equ.S.T. CHIROPRACTIC

Name: _____

DOB: _____

Patient Condition

Reason for visit? _____

When did your symptoms appear? _____

Does anything improve your pain? If YES, please list: _____

How often do you experience these 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)

Symptoms (Check all that apply): [ ] Burning [ ] Sharp [ ] Shooting [ ] Radiating [ ] Numbness [ ] Tingling [ ] Tightness [ ] Ache

Please rate the severity of your pain: (No Pain) 1 2 3 4 5 6 7 8 9 10 (Worst Pain)

Does it interfere with your: [ ] Work [ ] Sleep [ ] Daily Routine

What services or treatment have you already received for your condition? [ ] Medications [ ] Surgery [ ] Physical Therapy [ ] Chiropractic services [ ] Massage [ ] Other _____

Have you seen another doctor for this condition? [ ] Y [ ] N….If yes, whom and where?

_____

Have you ever seen a chiropractor before? [ ] Y [ ] N…If yes, Facility name: _____

Please list any relevant x-rays or exams that we may ask for in order to further treat you including where they were taken and who they were taken by: _____

_____

Medications & Supplements	Dose & Purpose	Allergies

Tobacco Use	Alcohol Use	Activity Level
[ ] None [ ] Former [ ] Few [ ] 1 pack per day [ ] 2 or more packs	[ ] None [ ] Former Alcoholic [ ] Light/Moderate [ ] Heavy	[ ] None [ ] Light [ ] Moderate [ ] Vigorous

Equ.S.T. CHIROPRACTIC

Name: _____

DOB: _____

Please circle or check below to indicate if you HAVE any of the following conditions:

(If a family member had any of the following, please include these details in the "Family History" section)

Alcoholism	Liver Problems
Arthritis	Menopause
Asthma	Menstrual Problems
Bleeding Disorder	Migraine Headaches
Breast Lump	Miscarriage
Broken Bones	Nausea/vomiting
Cancer	Neurological Disorder
Cataracts	**NONE**
Chemical Dependency	Osteoporosis
Chest Pain	Pacemaker
Constipation	Pancreatitis
Depression/Anxiety	Parkinson's Disease
Diabetes	Psychological Disorder
Digestive Problems	Pinched Nerve
Dizziness	Pregnant
Emphysema	Prostate Problems
Epilepsy	Prosthesis
Fainting	Psoriasis
Fatigue	Rheumatoid Arthritis
Fever/Chills	Scoliosis
Fibromyalgia	Significant weight change
Fractures	Sinus Problems
Frequent Urination	Sprain/Strain
Gall Bladder problems	Stroke/Heart Attack
GERD	Suicide Attempt
Glaucoma	Thyroid Problems
Gout	TMJ Problems
Headaches	Tuberculosis
Hearing Problems	Tumor
Heart Disease	Ulcer/s
Hernia	Vaginal Infections
Herniated Disc	Varicose Veins
STDs	**Other- Please List**
High Blood Pressure	
High Cholesterol	

Family History: (grandparents, parents or siblings)

[ ] Scoliosis [ ] Cancer
[ ] Rheumatoid Arthritis
[ ] Multiple Sclerosis
[ ] Diabetes [ ] Parkinson's disease
[ ] Heart Disease [ ] Stroke
Other: _____

Hospitalizations:

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Injuries, Broken bones, Dislocations and Surgeries with dates:

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Updated 07/23/2023