NEW PATIENT INFORMATION

This clinic specializes in structural, muscular, nutritional and nerve related conditions. Examinations are done routinely to determine the nature and extent of the problem. These exams may consist of blood profiles, urinalysis, orthopedic, neurological and kinesiological tests, etc., depending on what is necessary. More detailed or specific examinations may be needed in complex or chronic cases.

Date_____

Name_____ Address _____

City, State, Zip_____ Home Phone No._____Cell Phone_____

Email: _____Soc. Sec. No. _____ Birthdate _____ Age_____ Sex_____

Number of children_____ Marital status: M S W D Spouse's name (or parent)_____

Occupation _____ Employer _____

Address_____ Work Phone No._____

Spouse's Occupation_____ Employer _____

Do you have x-rays?_____ Date taken_____ Where?_____

List your chief complaints in order of severity:

(1)_____ For how long?_____

(2)_____ For how long?_____

(3)_____ For how long?_____

What functions are you unable to perform or induce pain upon performance?

List in order of severity. (Example: sitting, walking, bending, lying down, etc.)

1. _____ 3. _____

2. _____ 4. _____

Does this interfere with your normal living and work? _____ If yes, explain_____

Have you lost any days of work?_____ If yes, explain_____

Other Doctors seen for this condition(s)_____

Types of treatments_____

List any medications you are currently taking_____

List any vitamins you are currently taking_____

List any allergies you have_____

List any surgeries you have had including dates_____

_____

_____

What is your Blood Type? _____Who to contact in case of Emergency?_____

Is this automobile accident related?_____ Is this Workman's Compensation related?_____

Insurance Company and address (if card is not available)_____

Name of person insured _____Relationship to insured_____ S.S.#:_____

Policy #:_____ Birthdate of Insured_____Medicare #_____

Some insurance policies provide chiropractic coverage; however, the patient is personally responsible for payment of services rendered. This clinic does not accept assignment for Medicare or Medicaid.

FEES PAYABLE WHEN HEALTH SERVICES RENDERED

I affirm the above information is factual. I am not at Dimensional Health to obtain information for, or represent directly or indirectly any medical, food, drug or governmental agency (local, state or federal). I also accept full responsibility for payment of fees.

Patient's signature_____

Whom may we thank for referring you to our office?_____

Additional Comments:_____

_____

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