NEW PATIENT FORM – MCINTOSH CHIROPRACTIC

ADMINISTRATIVE DATA

First Name: _____ Last Name: _____

Referred By: _____ Date Filled out: _____

Email: _____

Phone: Cell/home:_____ Work: _____

Mailing Address:

_____ _____ _____ _____

(House number/Apt/Street) (City) (State (2 letter)) (ZIP)

Age: _____ Birth Date: _____ Social Security #:_____

Occupation: _____

Employer: _____

Marital Status: _____ Number of Children: _____

Spouse's Name : _____

Spouse's Occupation: _____

Spouse's Employer: _____

Spouse's Health Status:_____

Emergency Contact: _____ Phone: _____

INSURANCE INFORMATION AND SIGNATURES

Name of party responsible for payment: _____

Phone: _____

Do you have health insurance? (check one) ____ No ____Yes

If Yes, Name of Company : _____ Policy #: _____

If an auto accident please provide:

Insurance Company Name: _____ Claim # : _____

Contact Person:_____ Phone: _____

Name of the Insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

_____ _____

(Patient's Signature) (Date)

_____ _____

(Spouse/Guardian's Signature) (Date)

NEW PATIENT FORM – MCINTOSH CHIROPRACTIC

Last Name: _____ First Name: _____ Date: _____

CURRENT COMPLAINTS

Nature of Injury (check one): ____ Automobile ____ Work ____ Other

Please Describe: _____

_____

_____

Date of Injury: _____ Date Symptoms Appeared: _____

Have you ever had same condition? (check one): ____ No ____ Yes If yes, when? _____

List other practitioners seen for this injury/condition: _____

_____

Have you ever been under chiropractic care? (check one): ____ No ____ Yes

If yes, please describe: _____

_____

_____

MEDICAL HISTORY

Have you been treated for any conditions in the last year? (check one): ____ No ____ Yes

If yes, please describe: _____

_____

_____

Date of last physical exam: _____ Is there a chance that you are pregnant? ____ No ____ Yes

Have you had X-rays taken? (check one): ____ No ____ Yes

If Yes, where and when?: _____

What medications are you taking and for what conditions (Please list dosage and amounts, etc):_____

_____

_____

What vitamins, minerals, or herbs do you currently take? (Please list for what condition, dosage, and frequency): _____

_____

_____

_____

FAMILY HISTORY

Family members – List present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.):

_____

_____

_____

_____

NEW PATIENT FORM – MCINTOSH CHIROPRACTIC

Last Name: _____ First Name: _____ Date: _____

HAVE YOU EVER?

Had broken bones?: ____ No ____ Yes Briefly explain: _____

_____

Been hospitalized? ____ No ____ Yes Briefly explain: _____

_____

Been in auto accident? ____ No ____ Yes Briefly explain: _____

_____

Had Sprains/Strains? ____ No ____ Yes Briefly explain: _____

_____

Been struck unconscious? __ No ____ Yes Briefly explain: _____

_____

Had surgery? ____ No ____ Yes Briefly explain: _____

_____

QUESTION check one ->	NO	YES
Do you experience pain every day?		
Do your symptoms interfere with daily life?		
Does pain wake you up at night?		
Are your symptoms worse during certain times of the day?		
Do changes in weather affect your symptoms?		
Do you wear orthotics?		
Do you take vitamin supplements?		

What activities aggravate your symptoms?: _____

_____

_____

HABITS (check one ->)	None	Light	Moderate	Heavy	**HABITS** (check one ->)	None	Light	Moderate	Heavy
Alcohol					Appetite				
Coffee					Soft Drinks				
Tobacco					Water				
Drugs					Salty Foods				
Exercise					Sugary Foods				
Sleep					Artificial Sweeteners				

NEW PATIENT FORM – MCINTOSH CHIROPRACTIC

Last Name: _____ First Name: _____ Date: _____

HAVE YOU EVER SUFFERED FROM…(check yes or no for each):

	Yes	No		Yes	No		Yes	No
Alcoholism			Ears Ringing			Nervousness		
Allergies			Excessive Menstruation			Nosebleeds		
Anemia			Eye Pain or Difficulties			Pacemaker		
Arteriosclerosis			Fatigue			Polio		
Arthritis			Frequent Urination			Poor Posture		
Asthma			Headache			Prostate Trouble		
Back Pain			Hemorrhoids			Sciatica		
Breast Lump			High Blood Pressure			Shortness of breath		
Bronchitis			Hot Flashes			Sinus Infection		
Bruise Easily			Irregular Heart Beat			Sleep problems or Insomnia		
Cancer			Irregular Cycle			Spinal Curvatures		
Chest Pain			Kidney Infection			Stroke		
Cold Extremities			Kidney Stones			Swelling of ankles		
Constipation			Loss of memory			Swollen Joints		
Cramps			Loss of balance			Thyroid Condition		
Depression			Loss of smell			Tuberculosis		
Diabetes			Loss of taste			Ulcers		
Digestion Problems			Lumps In Breast			Varicose Veins		
Dizziness			Neck Pain or Stiffness			Venereal Disease		
Other (list):								