New Client Information (Adult)

Date_____

Who are you?

Client's Name_____

Address_____

City, State, Zip_____

Home Phone_____ Cell_____

Status Minor Single Married Divorced Widowed

Birthdate_____ Age_____

E-mail_____

How would you prefer to be contacted?_____

Who do we contact in case of emergency?

Contact_____Phone_____

Are you employed?

If so, employer_____ Phone_____

Address_____

Do you have additional doctors?

PCP_____ Phone_____

Date of last visit_____

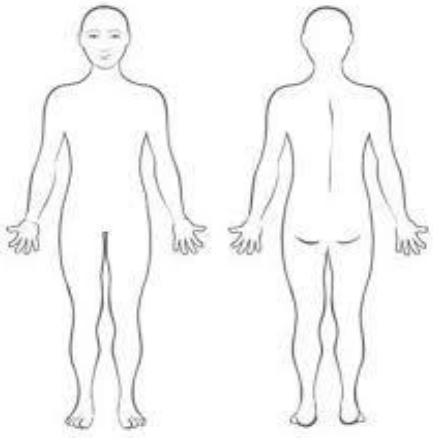
Previous Chiropractor_____

Do you experience any of these health issues?

(P–past or **C**-current**)**

__Work injury	__Pulled muscles	__Car Accidents
__Neck pain	__Mid back pain	__Low back pain
__Shoulder pain	__Leg / Hip pain	__Wrist / arm pain
__Scoliosis	__Numbness	__Stiffness
__Sleeping Issues	__Fatigue	__Weight Issues
__Digestive Issues	__Kidney Issues	__Respiratory Issues
__Ear Issues	__Constipation	__Diarrhea
__Asthma	__Ulcers / colitis	__Frequent colds /flu
__Allergies	__Sinus Issues	__Liver Issues
__Arthritis	__Shingles	__Alcohol / drug abuse
__Hepatitis	__HIV / Aids	__ Excessive Gas
__Cancer	__Thyroid Issues	__High / low blood pressure
__Stroke	__Heart Attack	__Congenital Heart Defects
__Chemotherapy	__Fractures	__Implants
__Impotence	__Depression	__Gall Bladder Issues
__Hemorrhoids	__HRT	__ Menopausal Issues
__PMS	__Pregnant (Now)	__Breast lumps / soreness
__Physical Stress	__Emotional Stress	__Chemical Stress

Where are your problem areas?



FRONT ***BACK***

How long have you had these issues?

_____Days_____Months_____Years

Date issues began_____

How issues began_____

_____

Is the condition better? __Yes __No

Is the condition getting worse? __Yes __No

Is the condition staying the same? __Yes __No

Would you like to find the cause? __Yes __No

Does this issue interrupt your?

Work Sleep Patterns Daily Life Social Life

If so explain_____

_____

What methods have you tried?

Exercise Physical Therapy Surgery Massage

OTC Meds Prescription Meds Nothing

Results Obtained_____

_____

Current Medications

_____

_____

_____

_____

Current Supplements

_____

_____

_____

_____

Past Surgeries

_____

_____

Past Serious Accidents / Injuries

_____

_____

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Rate your overall health from 1-10: _____

What results are you trying to achieve?

Reduce Symptoms Restore Health and Function Maintain Health and Function

I will be paying by

Cash Check Master Card Visa

Signature of Agreement

- I understand and agree that health insurance is an agreement between the carrier and myself. I 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 care, any fees for professional services rendered to me will be immediately due and payable.
- Our office policy requires payment in full for all services rendered at the time of service, unless other arrangements have been made in advance. If account becomes past due and is not paid within 90 days of the date of service, you will be responsible for legal fees, collection fees and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during evaluation and treatment. I also authorize the provider to release any information required to process or submit claims on my behalf.
- I understand the above information and correctly completed this form to the best of my knowledge and understand that it is my responsibility to inform the office of any changes to the information that I have provided.
- My signature acknowledges that I have been offered a copy, read and reviewed this office's HIPPA policy. This policy reviews how my health information may be used and disclosed. I understand that I should carefully review this policy. This policy may be altered or amended at any time and will expire seven years after the date signed below.

Signature_____ Date_____/_____/_____

Adult Client Parent or Guardian Spouse

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential. If a claim is submitted to a carrier or third party on your behalf, your health information on this form may be shared with that carrier or third party.

Physician use only

Issue	Onset	Provocative	Pallative	Quality	Radiation	Severity	Temporal

ADDITIONAL NOTES: