PRENTICE Family CHIROPRACTIC LLC

Date: _____

NEW PATIENT HISTORY

Name: _____ Birth date: ____/____/____ Age:____

Address: _____

City: _____ State:_____ Zip: _____

Phone:_____ Alternate Phone: _____

Social Security #: _____ E-mail Address: _____

Employer: _____ Occupation: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Number of children:_____

Person to contact in case of emergency: Name: _____ Phone: _____

How did you hear about our office? _____

Insurance Company: _____ Policy #: _____ Group #: _____

Policy Holder's Name: _____ Date of birth: _____ Social Security #: _____

What is the main problem that you would like the doctor to assist you to improve?_____

When did the problem start? _____

What has helped the condition? _____

What has aggravated the condition?_____

If injury, how did it occur? _____

Severity of symptoms: 0 1 2 3 4 5 6 7 8 9 10 (worst ever)

Have you ever had these symptoms before? ☐ No ☐ Yes, explain: _____

Are you interested in fully handling the problem or just temporary relief? _____

CHIROPRACTIC HISTORY:

Have you ever been to a chiropractor before? _____

If yes, Doctor's name? _____

Date (approx.) of last chiropractic visit: _____ Reason: _____

How long were you under care?_____

Have you ever been introduced to wellness chiropractic? _____

FAMILY HISTORY:

Has anyone in your immediate family had, or do they currently have, any of the following problems? (Check all that apply)

☐ Food Allergies ☐ Cancer ☐ Diabetes ☐ Headaches
☐ Skin Disorders ☐ Back Problems ☐ Neck Problems ☐ Arthritis
☐ Tuberculosis ☐ Heart Disease ☐ Hypertension ☐ Allergies
☐ Digestive Problems

LIFE-STYLE HISTORY:

List all accidents (auto, work, trauma, etc.) You have had, the dates of occurrence and any lasting or recurring pain or problems:

_____

_____

Are you currently being treated by another doctor? _____

If yes, what are you being treated for? _____

List any current medications: _____

List any past surgeries and date: _____

How many hours of sleep do you usually get? _____ Are they interrupted? ☐ Yes ☐ No

How much alcohol do you consume? _____

How many cigarettes do you smoke per day? _____

Do you exercise regularly? ☐ No ☐ Yes, If so, what types? _____

On a scale of 1-10, 10 being optimum, how would you rate your diet? _____

On a scale of 1-10, 10 being optimum, how would you rate your overall health? _____

How would you rate your stress levels? (1 = no stress, 10 = extreme stress) _____

FEMALE PATIENTS ONLY

Do you experience any of the following symptoms: Menstrual pain? ☐ Yes ☐ No Cramping? ☐ Yes ☐ No

Irregular periods? ☐ Yes ☐ No Difficulty with getting pregnant? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No If yes, how far along? _____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid for by my insurance company.

We must emphasize that as health care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We will follow up on submitted claims to a reasonable degree but in the event that your insurance company delays payment or does not pay your claim, you will be responsible for the outstanding balance and it will be up to you to get reimbursed. Fees must be paid regardless of insurance coverage.

I authorize the staff to perform any necessary services needed during my care. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ **Date:** _____