Most Chiropractic

New Patient History

Patient Data:

First Name:______________________ Last Name:______________________

Date of Birth:______________ Age:__________ Social Security Number:______________

Address:____

City:______________ State:__________ Zip Code:______________

Phone Number: (H)______________ (C)______________ I Prefer To Be Called: Home Cell

Email Address:____

Occupation:______________________ Employer:______________________

Primary Care Physician:______________________ May We Contact Your PCP?:__________

Who May We Thank For Referring You?:______________________________

Emergency Contact:______________________ Phone Number:______________________

Complaints:

Primary Complaint:____

Date When Symptoms First Appeared: ______________________________

Did The Symptoms Begin: Gradually __________ Suddenly__________ Progressively Over Time:__________

What Makes The Symptoms Increase?:______________________________

What Relieves The Symptoms?:______________________________

Type Of Pain: Achy Burning Dull Sharp Stiff Throbbing Spasm Tingling Numbness Weakness Radiating Shooting

How Often Do You Experience These Symptoms?: Occasionally Frequently Constantly

Please Rate The Intensity Of Your Symptoms On A Scale Of 1-10 (1 Being No Symptoms, 10 Being Extreme):______________

Please List Previous Treatments For This Condition:______________________________

Secondary Complaint:____

Date When Symptoms First Appeared: ______________________________

Did The Symptoms Begin: Gradually __________ Suddenly __________ Progressively Over Time:__________

What Makes The Symptoms Increase?:______________________________

What Relieves The Symptoms?:______________________________

Type Of Pain: Achy Burning Dull Sharp Stiff Throbbing Spasm Tingling Numbness Weakness Radiating Shooting

How Often Do You Experience These Symptoms?: Occasionally Frequently Constantly

Please Rate The Intensity Of Your Symptoms On A Scale Of 1-10 (1 Being No Symptoms, 10 Being Extreme):______________

Do You Smoke?________ If Yes, How Many Packs Per Week?__________ Have You Ever Smoked In The Past?__________

Do You Exercise?________ If Yes, How Many Times Per Week And What Type?______________________

Do You Take Birth Control?__________ Have You Ever Taken Birth Control In The Past?______________________

Do You Consume Alcohol?__________ If Yes, How Many Drinks Per Week?____________

Do You Consume Caffeine?__________ If Yes, How Many Drinks Per Day?____________

Do You Have A High Stress Level?________ If Yes, List Reasons:______________________

Please List Any Medications/Vitamins You Are Currently Taking: ______________________

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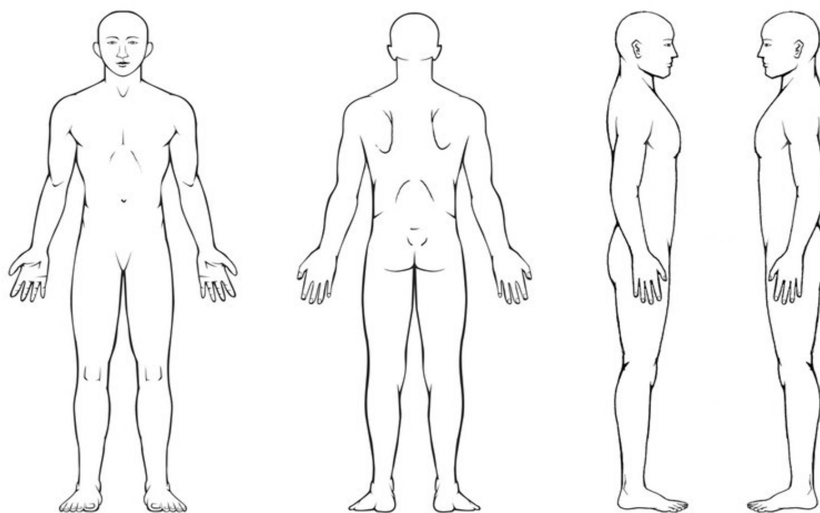
Please Mark The Areas Of Your Complaint On The Diagram With The Following Indicators:

PPP- Pain
NNN- Numbness
TTT- Tingling
BBB- Burning
CCC- Cramping
XXX- Other



Please List All Accidents, Injuries, Falls, Etc: ____

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Please Circle If You Have Had Any Of The Following:

AIDS/HIV	Disc Degeneration	High Cholesterol	Parkinson's	Vaginal Infections
Allergy Shots	Diabetes	Kidney Disease	Pinched Nerve	Venereal Disease
Anemia	Emphysema	Liver Disease	Pneumonia	Whooping Cough
Anorexia	Epilepsy	Measles	Prosthesis	Allergies (Please List Below)
Arthritis	Glaucoma	Mumps	Psychiatric Care	____________
Asthma	Goiter	Migraine	Rheumatic Fever	____________
Breast Lump	Gonorrhea	Mononucleosis	Rheumatoid Arthritis	____________
Bronchitis	Gout	MS	Scarlet Fever	____________
Bulimia	Heart Disease	Miscarriage	Stroke	____________
Cancer	Heart Attack	Mumps	Suicide Attempt	____________
Cataracts	Hepatitis	Osteoporosis	Thyroid Problem	____________
Chicken Pox	High Blood Pressure	Pacemaker	Tonsillitis	____________

Consent To Treat: I hereby authorize Most Chiropractic doctors and assistants to perform examinations, physical therapy, and/or diagnostic testing and any other treatments that are medically necessary today and through the course of my treatment.

Signature:________________________ **Date:**________________________

Consent to Treat a Minor Child: I, ________________________, hereby give my permission to Most Chiropractic to treat my minor child with examinations, physical therapy and other non-invasive procedures that are medically necessary.

Parent/Guardian Signature:________________________ **Date:**________________________

Acknowledgment of Privacy Practices: By signing on the line below, I am indicating that I have been given a copy of the Health Insurance Accountability and Portability Act to read. I was also informed by Most Chiropractic that a copy of these privacy practices can be made available to me at any time upon request.

Signature:________________________ **Date:**________________________

Assignment and Release: I certify that I, or my dependent(s), have insurance coverage and assign directly to Most Chiropractic LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named insurance company or companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature:________________________ **Date:**________________________