

New Patient Information

Full of Life Chiropractic
6030 Santo Road Suite D
(858) 541-0505

Date _____

First Name _____ Middle Initial _____ Last Name _____

How should we refer to you (nickname) _____

Social Security Number _____ - _____ - _____ Date of Birth _____ (mm/dd/yyyy)

Address _____ City/State/Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Home E-mail _____

Employer _____ Work Address _____

Married (Y/N) _____ Children (#) _____ Spouses Name _____

Emergency Contact _____ Telephone Number _____

How did you find our about our office? _____

If referred, by whom? _____

Current Complaints

Nature of Injury: Automobile Work Other

Please describe the reason for your visit today:

Date of Original Injury _____ Date Symptoms Appeared _____

Other practitioners seen for this injury/ condition _____

PLEASE CHECK THE CHOICE THAT BEST DESCRIBES YOUR PAIN.

Describe the pain (check all that apply):

____ Sharp ____ Soreness ____ Throbbing ____ Tingling ____ Dull ____ Stiffness ____ Spasm
____ Burning ____ Ache ____ Weakness ____ Numb

Rate the Intensity of your Pain (0=no pain, 10 = terrible or unbearable pain):

0 1 2 3 4 5 6 7 8 9 10

New Patient History

(Please check all that apply)

	Present	Past	Father	Mother
ALLERGIES				
ASTHMA				
BACK OR NECK INJURIES				
CANCER				
SPORTS INJURIES				
DIABETES				
DIZZINESS/NAUSEA				
FATIGUE				
FOOT OR ANKLE PAIN				
HEADACHES				
HIGH BLOOD PRESSURE				
HEART TROUBLE				
JAW PAIN				
LOW BACK PAIN				
MID-BACK PAIN				
NECK OR SHOULDER PAIN				
SCOLIOSIS				
MENSTRUAL/OVULATION PROBLEMS				
STROKE				
EAR INFECTIONS				
ARM, HAND, LEG, OR FEET PROBLEMS				
DIGESTIVE PROBLEMS				
SWELLING OF JOINTS				
NERVOUSNESS				
SLEEP PROBLEMS				
LOSS OF MEMORY				
OTHER				

	Minor	Major
Auto Injuries		
Work Injuries		

	PAST	PRESENT	MODERATE	HEAVY
ALCOHOL USE				
CAFFEINE USE				
TOBACCO USE				

Have you ever been adjusted by a chiropractor? (Y/N) _____ If so, by whom _____

Approximate date of last adjustment? _____

Have you ever had surgery (Y/N) _____ If so, when and explain _____

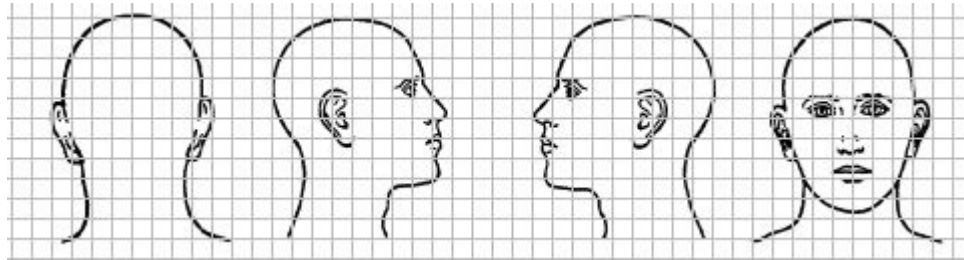
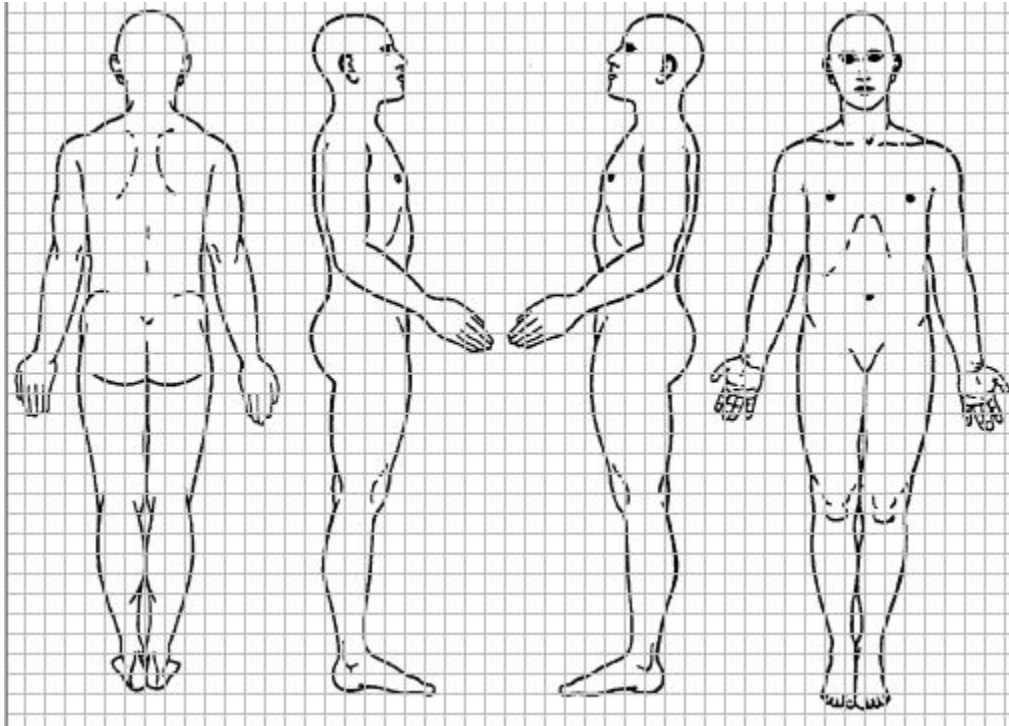
List any fractures, blows to the head, or stitches _____

Are you taking any medications (Y/N) _____ If so, please list _____

Locate and document your pain with the body diagram.

Please use the following letters to indicate TYPE and LOCATION of the symptoms you are currently experiencing.

A= Ache **B**= Burning **P** = Pins and Needles **N**= Numbness **S**= Stabbing **O**= Other



Please answer YES or NO to the following questions.

1. Do you experience pain every day? _____
2. Do these problems hinder your ability to do work or other routine activities? _____
3. Does your pain wake you up at night? _____
4. Are your symptoms worse during certain times of the day? _____
5. Do changes in weather affect your symptoms? _____
6. Do certain activities aggravate your symptoms? _____

INSURANCE INFORMATION

Insurance Company _____

Name of Insured _____

Birth Date of Insured _____ (mm/dd/yyyy) ID Number _____

Occupation of Insured _____

Relationship of Insured _____

Telephone Number of Insurance Company _____

Our office will provide insurance billing services for you, if you so desire, as a courtesy. Remember that you are ultimately responsible for any changes incurred in this office. It is your responsibility to pay any deductible amount, co-insurance and/or any other balances not paid by your insurance carrier. Your signature on this document indicates that you agree to pay any outstanding bills incurred in this office.

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**IN ORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND KEEP OUR PATIENT FEES
REASONABLE, WE EXPECT PAYMENT AT THE TIME OF SERVICE FOR CASH PATIENTS
AND THE CO-PAYMENT FOR REGULAR INSURANCE PATIENTS UNLESS PRIOR
ARRANGEMENTS HAVE BEEN MADE.**
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**The
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on on this form is true and correct to the best of my ability:

PATIENT'S NAME (PLEASE PRINT)

DATE

SIGNATURE OF PATIENT