

New Patient Form

Please fill out completely, print, sign and date the form and bring with you to your first appointment

Patient Name: Last _____ First _____ M _____ SS# _____

Address _____ City _____ State _____ Zip _____

Email Address: _____ Cell # _____ Home # _____

Date of Birth: _____ Referred By _____ Status: S M D W Gender M F

Occupation _____ Employer _____ Work # _____

Employer's Address _____ City _____ State _____ Zip _____

In Case of an Emergency:

Who should we contact? _____ Relationship: _____

Home Phone #: _____ Work Phone #: _____ ext. _____

Reason For Visit:

The reason for this visit is a result of: Work Sports Auto Chronic Trauma Unknown

When did the condition begin: _____ Is this condition getting worse? Yes No Unchanged

Describe what happened: _____

Describe your main complaint & its location: _____

Grade your Primary Complaints (how you feel today):

0	1	2	3	4	5	6	7	8	9	10	
No Pain											Unbearable Pain

How often are your symptoms present?

0-25% 26-50% 51-75% 76-100%

Describe the secondary complaint & its location: _____

Grade your secondary complaints (how you feel today):

0	1	2	3	4	5	6	7	8	9	10	
No Pain											Unbearable Pain

How often are your symptoms present?

0-25% 26-50% 51-75% 76-100%

Have you been treated by another provider for this condition? Yes No _____

Have you had any spinal X-Rays, MRI or CT Scans for your area(s) of complaint? Yes No list areas taken: _____

Please bring any films or reports related to your condition with you on your initial visit.

Have you ever been treated by a Chiropractor before? Yes No If so, whom? _____

Who is your Primary Medical Doctor? _____ Phone #: _____

Lifestyle Information: Do you...

<input type="checkbox"/> Yes <input type="checkbox"/> No smoke? _____ packs/day	<input type="checkbox"/> Yes <input type="checkbox"/> No drink alcohol? _____ units/day
<input type="checkbox"/> Yes <input type="checkbox"/> No exercise? How often? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No wear heel lifts?
<input type="checkbox"/> Yes <input type="checkbox"/> No take Vitamins or Supplements? (list below)	<input type="checkbox"/> Yes <input type="checkbox"/> No wear orthotics?
<input type="checkbox"/> Yes <input type="checkbox"/> No take Medications? (list below)	<input type="checkbox"/> Yes <input type="checkbox"/> No sleep well? How old is your mattress? __ yrs.

List all medications and/or supplements you take _____

For Women:

Yes No take Birth Control? _____ | Yes No Are you Pregnant? Weeks/LMP _____ ?

Patient Medical Health History:

List any allergies to foods, medications, etc.: _____

List any condition(s) you have or ever had: _____

List any past accidents with dates: _____

List any previous surgeries/treatments with dates: _____

Symptoms Survey:

Do you currently have or have you ever had any of the following conditions or diseases?

- | | |
|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Neck Pain or Stiffness | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease / Stroke / TIA (Circle) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Mid Back Pain or Stiffness | <input type="checkbox"/> Yes <input type="checkbox"/> No Neurological Conditions |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Lower Back Pain or Stiffness | <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Tension or Migraine Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No Fainting/Seizures/Epilepsy |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Tingling or Numbness in Arms / Hands | <input type="checkbox"/> Yes <input type="checkbox"/> No Osteoporosis / Osteopenia |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Tingling or Numbness in Legs / Feet | <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer, If yes, Please specify |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Shoulder / Elbow / Wrist Pain (Circle) | <input type="checkbox"/> Yes <input type="checkbox"/> No Chemotherapy / Radiation |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hip / Knee / Ankle Pain (Circle) | <input type="checkbox"/> Yes <input type="checkbox"/> No Alcohol / Drug Abuse |
| <input type="checkbox"/> Yes <input type="checkbox"/> No High/Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers / Colitis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty Breathing | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No Meningitis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Sinus Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes/Tuberculosis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Spine Surgeries/Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No Psoriatic Arthritis |

Family Medical Health History:

Do any members of your immediate family have or ever had any medical conditions listed above? If yes, please list:

Insurance Information:

Insurance Co.Name: _____ Tel# _____

Address: _____ City: _____ State: _____ Zip: _____

Insured's Name: _____ Date of Birth: _____

Insured's ID#: _____ Group #: _____ Relationship _____

Personal Injury / Worker Comp Ins. Co: _____ Tel# _____

Address: _____ City: _____ State: _____ Zip: _____

Claim #: _____ WCB Case #: _____ Date of Injury _____

I hereby authorize assignment of my insurance rights and benefits to be paid directly to the provider of services rendered at Motion Wellness & Chiro. It is the policy of some insurance companies to pay the subscriber (patient) directly in certain cases. I fully understand that if I receive any payment directly from my insurance company for services rendered by any provider at Motion Wellness & Chiro, I am solely responsible to sign over such insurance checks. In the event that I deposit these checks into my account or negotiate them, I am responsible for reimbursing the provider that rendered these services for an equal amount.

Motion Wellness & Chiro requires all payments in full for services rendered at the time of the visit, unless other arrangements have been made with the business manager. If you want to discuss any financial matters, please inform the front desk prior to treatment.

We encourage you to inform the front desk if you want to discuss any questions you have regarding our services or billing practices. This promotes a greater confidence and trust between our patients and staff, thus resulting in a more comfortable experience and healing environment. I understand the information in this form and completed it truthfully to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in the provided information that may occur in the future.

As a patient of Motion Wellness & Chiro or parent/legal guardian of the minor listed above, I hereby authorize the doctors at this office and their assistants to administer care as deemed necessary.

Patient's Signature / Parent or Guardian

Self / Relationship

Date