Activate Chiropractic
A Family Wellness Center

New Patient Information

Name_____

What You Prefer to be Called_____

Home Phone (_____)_____ Cell/Other Phone (_____) _____

Address_____ City_____
State_____ Zip_____

Age_____ Birth Date_____

How Many Children_____

Occupation_____

Employer_____

Work Phone (____)_____
Name of Wife or Husband_____

Referred by _____

E-Mail_____

Health Information

Purpose of this visit
_____

Other doctors seen for this condition
_____

Have you been treated for any health condition during the past year? ( ) Yes ( ) No

Describe_____

Date of last physical exam_____

Name of your family physician_____

What city are they located in?_____

List any medications you take
_____

List any surgeries you have had
_____

List any serious illnesses you have had

_____

List any serious accidents, falls, or trauma in your life

_____

Check any symptoms or problems you are having

( ) Headaches
( ) Neck pain or stiffness
( ) Dizziness
( ) Buzzing or ringing in ears
( ) Loss of energy
( ) Blurred vision
( ) Sinus problems
( ) Stomach or bowel problems
( ) Upper back pain or stiffness
( ) Arm pain or numbness
( ) Loss of strength in hands
( ) Mid back pain or stiffness
( ) Heart problems
( ) High blood pressure
( ) Asthma
( ) Other _____
( ) Low back pain or stiffness
( ) Leg pain or numbness
( ) Loss of strength in legs
( ) Vertigo
( ) Cancer
( ) Arthritis
( ) Spinal Curvature

Additional information

_____

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Payment is expected at the time services are provided

Do you have chiropractic insurance benefits? ( ) Yes ( ) No ( ) Don't Know

I understand and agree that I am personally responsible for all professional services received in this office. I understand that this office will provide me with forms to assist me in collecting from any insurance company. I authorize my chiropractor to release information regarding my care to insurance companies. I understand that if I suspend or terminate care, any and all fees will be immediately due and payable.

Patient Signature_____
Date_____

Information Taken By _____
Date_____