ACTIVATE CHIROPRACTIC
A Family Wellness Center

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Confidential New Patient Information

Name_____ What You Prefer to be Called_____

Social Security Number_____Cell Phone (_____) _____

Address_____ City_____ State_____ Zip_____

Age_____ Birth Date_____Marital Status: Married____ Single____Widow(er)____Divorced____

Do you have children?_____If so, names and ages_____

Occupation_____ Employer_____

Work Phone (____)_____ Name of Wife or Husband_____

Emergency Contact_____Phone Number_____

How Did You Hear About Us?_____

E-Mail_____

Are you pregnant? Y N If so, what trimester_____Last known menstrual period_____

Health Information

Purpose of this visit_____

Duration of Symptom(s)_____

Other doctors consulted for this condition(s):

Diagnosis: _____

Results:_____

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

Describe_____

Name of your family physician_____ Date of last physical exam_____

List any surgeries you have had:

Type _____ When_____

Type _____ When_____

Type _____ When_____

See other side

List serious accidents and falls:

What _____ When_____

What _____ When_____

List any medications and/or supplements you take_____

_____

List any serious illnesses you have had:

What _____ When_____

What _____ When_____

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
( ) Nose bleeds
( ) Diarrhea
( ) Constipation
( ) High blood pressure
( ) Upper back pain or stiffness
( ) Arm pain or numbness
( ) Loss of strength in hands
( ) Mid back pain or stiffness
( ) Heart problems
( ) Lung condition
( ) Asthma
( ) Joint Pain
( ) Fatigue
( ) Kidney disease
( ) Loss of sleep
( ) Low back pain or stiffness
( ) Leg pain or numbness
( ) Loss of strength in legs
( ) Digestive issues
( ) Cancer
( ) Arthritis
( ) Painful urination
( ) Eye sight changes
( ) Nausea
( ) Allergies
( ) Other_____

Additional information _____

_____

Family Medical History

Has a blood relative (Parent, Grandparent, Sibling or Child) ever experienced any of the follow? If so, please describe.

( ) Heart Disease_____

( ) Cancer_____

( ) Stroke_____

( ) High Blood Pressure_____

( ) Diabetes_____

( ) Back Problems_____

( ) Migraine_____

( ) Asthma_____

( ) Depression_____

( ) Arthritis_____

( ) Other_____

Payment is expected at the time services are provided

I understand and agree that I am personally responsible for all professional services received in this office. 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_____