WELCOME: NEWTON CENTER CHIROPRACTIC

Confidential Patient Information

One of the greatest compliments we can receive is when one of our patients refers a friend, co-worker or family member to us for care. Before you begin filling out this form could you ***please write down the name of the person who referred you to us so that we may thank him or her*****.________________________________**

Name________________________________ Date____________________ SS#____________________________

Address____ City_____________ State __________Zip___________

Email ____ Date of Birth _______________ Age _____ Sex: M F

Preferred Language___________ ***Ethnicity*****: (Circle One)** Hispanic or Latino / Not Hispanic or Latino

Race**: (Circle One)** American Indian/Alaska Native/Asian/Native Hawaiian or other Pacific Islander/Black or African American/White

Home Phone ______________________ Cell # _________________ Work # _________________

Single _______ Married _______ Minor _______ Student _______ Widowed _______ # of Children _______

Employer ____ Occupation________________________

Work Address ___________________________________ City _______________________ State ____ Zip_____

Emergency Contact _________________________________ Emergency Contact Phone ___________________

Spouse or Parent Name ____

Name of person responsible for your account ____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my Doctor if I, or my minor child, ever have a change of health. I certify that I, and /or my dependant's have insurance coverage with ______________________ and I assign directly to Newton Center Chiropractic 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. Newton Center Chiropractic may use my health care information and my disclose such information to the above mentioned insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

______________________________________ ______________________
Signature of patient, parent or guardian Date

______________________________________ ______________________
Please print name of person signing above Relationship to patient

1. Reason for appointment today: ____

____

What event or situation caused your injuries: (Ex: trauma, sport, activity) ______________________________

____

Have you ever had this problem/pain before? When? Describe. ____

____

Does anyone in your family have similar problems? Who?____

Other treatment received for this problem:____

____

2. Daily Health Habits:

What is your typical exercise/activity regime?____

Describe your work situation # of hours of work per /retired/student. _____________________________

Stress level at work ________________________ Postural position most of the time at work ______________

Amount of physical labor at work ____

Describe your diet (poor, healthy, special diet, supplements etc…)____________________________________

____

Describe your use of Alcohol ___________________________________ Caffeine 1 cup a day / 2-4 cups a day

Cigarettes **(Circle one)** Current every day smoker/ Current some day smoker/ Former smoker / Never smoker

Have you used ice/health/pain pills for your symptoms? Describe ____________________________________

____

List medications you usually take: ____

List any allergies:____

Height __________________ ***Weight*** __________________ ***Blood Pressure*** ____________________________

3. Health Goals **(**Check all that apply):

Correction ___ Pain Relief ___ Improved function____ Return to Activity ___Wellness ___ Preventative ____

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: ____ Date:_______________