

# 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: \_\_\_\_\_