NEW PATIENT HISTORY

The purpose of this office is to educate as many families as possible about the spinal condition known as Vertebral Subluxation. Vertebral Subluxation destroys an optimally functioning spine and your ability to have Optimal Heath. Your experience with this office will not only be of healing but also of learning the truth about **Optimal Health and Healing.**

Name: _____ Date: _____
Address: _____
City/State/Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Birth Date: _____ Age:_____ Social Security:_____
Marital Status: **M W D S** Email: _____
Your Employer: _____ Occupation: _____
Spouse's Name: _____ Spouse's Employer: _____
Children's Names and Ages: _____
Who may we thank for referring you? _____
When did you last see a Chiropractor? _____
Why? _____
What spinal maintenance programs were you given to maximize the future stability of your spine?
_____
Did you follow it? _____ If not, why? _____
Are you here because of a recent auto or work injury? _____ Date of Accident:_____
Other doctors you've seen recently: _____
Medications you take: _____
Surgeries you have had: _____
Ever diagnosed with cancer? _____ What kind: _____
Who is financially responsible for this bill? _____
Method of Payment: Cash [ ] Check [ ] Credit Card [ ] Insurance [ ]
Emergency Contact:_____ Phone: _____

A. Subluxations can cause malfunction in any part of the body. Please check health issues you are experiencing currently or have had in the past.

[ ]Lower Back	[ ]Arm/Hand Problem	[ ]Carpal Tunnel Syndrome
[ ]Neck Pain	[ ]Leg/Foot Problem	[ ]Ear Infections
[ ]Headaches	[ ]Asthma	[ ]Frequent Colds/Infections
[ ]Upper/Mid Back Pain	[ ]Allergies	[ ]Spinal Curvature
[ ]Shoulder Pain	[ ]Sinus Problems	[ ]Digestive Problems

Other: _____

B. Subluxations can put pressure on nerves for long periods of time. How long have you had the above complaint(s):_____

C. Nerve pressure and irritation can be constant or occasional. How often do you have the above complaint?_____

D. Irritation to different nerve fibers can create different sensations. Is yours sharp, dull, throbbing, burning, numb, or achy?

_____

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E. Subluxations can cause weakening of the entire spine. Is yours worse in the AM, PM, or after activity? _____

F. The vast majority of our patients have experienced dozens of impacts that could cause Vertebral Subluxations. Help us discover a few of yours.

1. **How many total auto accidents have you been in? (please circle)**
   5+ 3-4 1-2 0
   Motorcycle accidents? Yes No
2. **Which of the following sports have you been involved in? (please circle)**
   Football Basketball Soccer Field Hockey Gymnastics Horseback Riding
   Martial Arts Roller Blading Other: _____
3. **Have you ever… (please check)**
   [ ] fallen down the stairs **[ ]** slipped on ice
   [ ] had a stress or strain while working **[ ]** had a sports injury
4. **Do you… (please check) [ ] sit more than four hours per day**
   [ ] drive more than two hours per day
   [ ] perform repetitive tasks (i.e. typing or lifting)

WHAT IS YOUR HEALTH PHILOSOPHY? What should you do to be healthy?

_____

HOW DO YOU WANT US TO HANDLE YOUR HEALTH?
Temporary Relief___ (Help the symptom but do not fix the cause of the problem)
Maximum Correction ___ (Correct the cause of the problem for maximum stability in the future)

1. **What are your favorite hobbies or activities:**_____
2. **Are your current health issues affecting your activities or hobbies?**
   _____
3. **One a scale of 1-10 (10 being the most, and 1 being the least).**
   _____ How committed are you at being at your maximum health potential?
   _____ How important is it for your family to be at their optimal health potential?
   _____ How committed are you to preventing arthritis and maximizing your spinal stability.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that New Hudson Chiropractic Wellness Center, P.C. will prepare any necessary reports and forms to assist me in making collection from the insurance company. Any amount authorized to be paid directly to the Chiropractic Office will be credited to my account on receipt. Regardless if I do not have insurance benefits or if my insurance company does not cover services rendered to me I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I also accept that the policy of this office requires payment due in full for all services, medical records, and x-rays before the release of any such documents to any entity which includes but is not limited to other doctors offices, patients, insurance companies, etc.

_____ _____
Patient's Signature Date

_____ _____
Guardian's Signature Authorizing Care for Minor Date