



**NEW PATIENT INFORMATION**

Welcome to our office! Please complete all questions.

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Chart #: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 E-mail: \_\_\_\_\_ Race: \_\_\_\_\_  
 Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
 Marital Status: *Married Widow Divorced Single* Cell Phone: \_\_\_\_\_  
 Your Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Spouse's Name: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_  
 Children's Names and Ages: \_\_\_\_\_  
 Favorite Hobbies or Interests: \_\_\_\_\_  
 Method of Insurance or Payment: \_\_\_\_\_

Current health complaints or reasons for consulting our office:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

Have you had same or similar problem (s) before? \_\_\_\_\_

If so, for how long? \_\_\_\_\_

Is this the result of an auto or work injury? \_\_\_\_\_ If so, when? \_\_\_\_\_

Father, mother, brother, sister, children with similar problems? \_\_\_\_\_

If so, who? \_\_\_\_\_

Other doctors you have seen for this problem: \_\_\_\_\_

Do you suffer from headaches? \_\_\_\_\_ If so, at what frequency?(Daily, Weekly, Etc.) \_\_\_\_\_

Surgeries you have had: \_\_\_\_\_

Medications you currently take: \_\_\_\_\_

Is there any chance you are pregnant? \_\_\_\_\_

Have you ever been diagnosed with cancer? If so, what kind? \_\_\_\_\_

**AUTHORIZATION AND RELEASE:** I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at Complete Wellness Chiropractic and Rehabilitation, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient or Guardian Signature:

Date:

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