CHIROPRACTIC FAMILY HEALTH CENTER
NEW PATIENT INFORMATION

Name_________________________________ ä Female ä Male Date______________________

What you prefer to be called_______________________Age_______ Date of birth_______________

Address______________________________ City _________________ State_____ Zip_________

Home phone__________________________ Cell phone__________________________________

Email Address____ SS#____________________

Employer_____________________ Occcupation________________Work Phone_______________

Emergency contact__________________________Relation_____________Phone______________

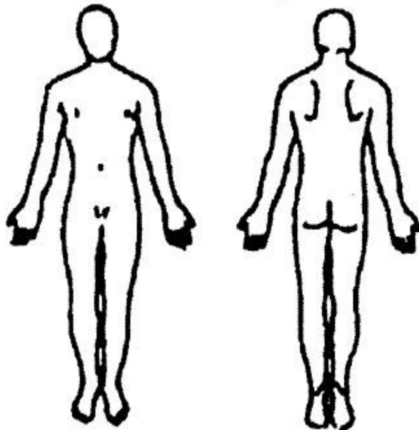
How did you hear about our office? ____

When did your condition begin? ____

Other Doctors seen for this condition____

Have you had the same or similar symptoms before? ä Yes ä No Date of prior condition____________

Mark Areas of Pain on Figures Below



List chief symptoms in order of severity:

(1)____

(2)____

(3)____

Have you had chiropractic care before? ä Yes ä No

Family Physician______________________________

Date of last physical___________________________

May we forward our findings to you family physician?

ä Yes ä No

Are you currently taking any medications?____

Previous surgeries____

Do you have a **PERSONAL** history of: ä Cancer ä Diabetes ä Heart Disease ä Stroke

Other serious illnesses ____

Check all symptoms that apply to you

ä Headache	ä Numbness in toes	ä Chest Pain	ä Unexplained weight loss
ä Neck Pain	ä Tingling Legs	ä Arthritis	ä Fever
ä Neck Stiffness	ä Loss of balance	ä Shortness of breath	ä Fatigue
ä Tingling in Arms	ä Dizziness	ä Back Pain	ä Night Sweats
ä Numbness in hands	ä Irritability	ä Sinus Trouble	ä Blood in Urine
ä Shoulder Pain	ä Knee Pain	ä Hip Pain	ä Pain unrelieved by rest

ä Other____ä Night Pain

For women: Are you pregnant? ä Yes ä No Are you taking birth control? ä Yes ä No

Health Insurance

Policyholder Name____ Date of Birth___________________

Workers compensation

Is your condition due to an Employment Related Injury? ä Yes ä No Have you reported it? ä Yes ä No

Days lost from work_________________________ Date of accident________________________________

Employer__________________________________Work Phone____________________________________

Supervisor__________________________________Supervisor#__________________________________

Auto Accident

Is your condition due to Automobile Accident? ä Yes ä No Date of accident______________________

Auto Accident Insurance Name _____________________________Claim #__________________________

Adjuster Name____Phone # _________________________

INSURANCE INFORMATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, 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 if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize Dr. Cory Hultman and his affiliated providers to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care, physical therapy, or any clinic services that they deem necessary in my case; and I further authorize them to disclose all or any part of my (patientøs) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or a family member or employer of the patient for all or part of the clinicøs charge, including , and not limited to hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patientøs employer.

I understand that if an insurance company initially pays for my treatment and later requests reimbursement from Chiropractic Family Health Center for any reason, I will be responsible for payment of my entire outstanding balance.

We invite you to discuss any questions you might have with us. The best health services are based on a friendly mutually understood relationship.

Patientøs or Guardianøs Signature:__________________________________Date______________________