The Health Connection
CHIROPRACTIC • ACUPUNCTURE • MASSAGE

New Patient Registration

First Name: Middle Initial:

Last Name:

Date of Birth: / / Age: **Social Security #:**

Gender: [ ] Male [ ] Female Height: Weight:

Marital Status: [ ] Married [ ] Single [ ] Life Partner [ ] Widow(er)

Address: **City/State/Zip:**

Home Phone: **Work Phone:** **Cell Phone:**

Email:

As a courtesy, we utilize EMAIL or TEXT MESSAGE for appointment reminders for our patients. Please choose ONE.

☐ **Text message (phone number):** _____ **Carrier:**_____

☐ **E-mail address listed above**

Occupation: **Employer:**

Emergency Contact: Relationship & Phone:

Financially Responsible Party: [ ] Self [ ] Other-Name, Address, Phone:

Family Physician: Phone:

How did you hear about us?

Insurance Information:

If you haven't done so already, please *pre-verify* your benefits. We are not responsible for any misquote of said benefits. If we will be assisting you in billing your insurance, please fill out the following:

Name of Insurance Provider: _____

Name of Policy Holder (Primary Plan Holder): _____

Policy Holder's Date of Birth: _____

Policy Holder's Address & Phone Number:_____

Member ID Number: _____

Patient/Guardian Signature:_____

Date: _____

Modified: 4/19/2017

Health History Questionnaire

What symptoms prompted you to seek care today? _____

When did you first notice this condition? _____

Intensity of pain? **0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10**

Mild Moderate Severe

Duration of symptoms? Constant (100%) Comes and Goes (50-75%) Infrequent (25-50%)

Have you tried any other treatments for this condition?

Ice Heat OTC medications Massage Therapy Rx medications Other:_____

Is there anything else The Health Connection should know about your current condition?

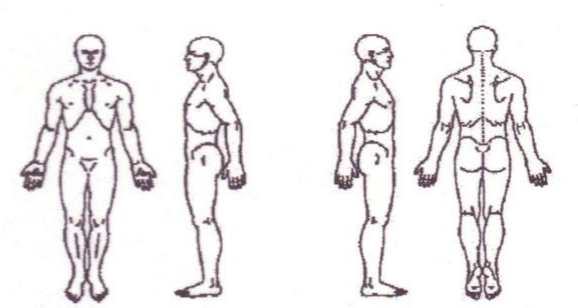
_____

Are there any other symptoms / conditions that you are experiencing?

1) _____

2) _____

3) _____



Past Medical History:

Please circle any that apply:

Mental Illness	Diabetes	Hepatitis	HIV+	AIDS	Herpes
High Blood Pressure	Heart Disease	Asthma	Allergies	Stroke	Arthritis
Chronic Fatigue	Gall Stones	Venereal Disease	Osteoporosis	Seizures	Parasites
Mononucleosis	Rheumatic Fever	Thyroid Problems	Kidney Stones	Ulcers	Cancer

Other _____

Surgeries / Traumas (types & dates): _____

Are You Pregnant? Y / N Estimated Due Date:_____ Any Complications? _____

Allergies (drugs, chemicals, foods, etc.) _____

Occupational Stress (chemical, physical, psychological) _____

Other: _____

Family Medical History:

Please circle any that apply:

Cancer	Heart Disease	Asthma	Diabetes	Stroke
Allergies	High Blood Pressure	Seizures	Other _____	

Medications:

Are you currently taking an Medications and/or supplements?_____

Habits:

Do you have a regular exercise program? Please describe: _____

How would you describe your diet? [ ] Good [ ] Fair [ ] Poor

Usage of:

Cigarettes _____ per _____ Caffeine _____ per _____ Alcohol_____ per _____

Signature_____ Date: _____

Modified: 4/19/2017

The Health Connection
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