# NEW PATIENT INTRODUCTION

☐ Worker's Comp ☐ Private Pay
☐ Group Ins. ☐ Medicare
☐ Other _____

Patient: ☐ Mr. ☐ Mrs. ☐ Miss _____ Date _____
(First) (Middle) (Maiden) (Last)

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Co-habit Birth Date: _____

Home address _____ Home Phone: _____
(Street) (City) (Zip)

Referred by: _____
(Full Name) (Address)

Referral source: ☐ Spouse ☐ Co-worker ☐ Insurance company ☐ Family
☐ Attorney ☐ M.D. ☐ Advertising Other _____

Patient employed by _____ Occupation: _____

Dept. _____ Employee No. _____

Business address _____ Business Phone: _____

Name of spouse _____
(First) (Middle) (Maiden) (Last)

Spouse/Co-habitor employed by _____

Dept. _____ Employee No. _____

Nearest relative not living with you _____ Relationship _____
(Name) (Address) (Phone)

Name of person legally responsible.
(if patient is a minor, name of parent, guardian, etc.) _____

## INSURANCE

Do you have Medicare? ☐ Yes ☐ No # _____

1st Insurance company _____ Address _____

2nd Insurance company _____ Address _____

Group No./Membership No. _____

Are you insured? ☐ Yes ☐ No Or dependent? ☐ Yes ☐ No

**NOTE: The following credit information is necessary when requesting insurance, monthly or weekly billing.**

Bank _____ Branch _____ Account No. _____

Social Security No. _____ Driver's License No. _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

**IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.**

If this account is assigned for collection and/or suit, collection costs and/or interest, and/or attorneys fees, and/or court costs will be added to the total amount due.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's records.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including MediCare, private insurance, and other health plans, to: _____

This assignment will remain in effect until revoked by the doctor in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

SIGNED _____ DATE _____

RESPONSIBLE PARTY _____ DATE _____

(over)

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## SYMPTOMS

HEAD:
- ☐ Headache
  - ☐ entire head
  - ☐ back of head
  - ☐ forehead
  - ☐ temples
  - ☐ migraine
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light-headedness
- ☐ Fainting
- ☐ Light bothers eyes
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Ringing in ears
- ☐ Buzzing in ears

NECK:
- ☐ Pain in neck
- ☐ Neck pain with movement
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Stiff neck
- ☐ Muscle spasms in neck
- ☐ Grinding sounds in neck
- ☐ Grating sounds in neck
- ☐ Popping sounds in neck
- ☐ Arthritis in neck

LOW BACK:
- ☐ Low back pain
- ☐ Low back pain is worse when:
  - ☐ working
  - ☐ lifting
  - ☐ stooping
  - ☐ standing
  - ☐ sitting
  - ☐ bending
  - ☐ coughing
- ☐ Pinched nerve in low back
- ☐ Slipped disc
- ☐ Low back feels out of place
- ☐ Muscle spasms
- ☐ Arthritis

MID-BACK:
- ☐ Mid-back pain
- ☐ Pain between shoulder blades
- ☐ Sharp stabbing pain in mid-back
- ☐ Muscle spasms

ABDOMEN:
- ☐ Nervous stomach
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea

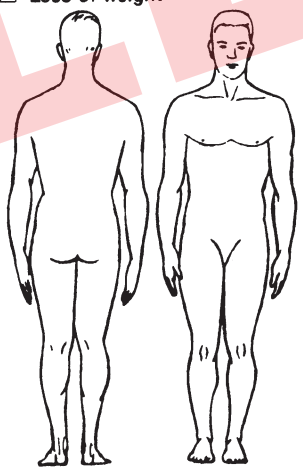
SHOULDERS:
- ☐ Pain in shoulder joint (R-L)
- ☐ Pain across shoulders
- ☐ Bursitis (R-L)
- ☐ Arthritis (R-L)
- ☐ Can't raise arm
  - ☐ above shoulder level
  - ☐ over head
- ☐ Tension in shoulders
- ☐ Pinched nerve in shoulder (R-L)
- ☐ Muscle spasms in shoulders

ARMS & HANDS:
- ☐ Pain in upper arm
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ Pinched nerve in arm
- ☐ Pinched nerve in fingers
- ☐ Sensation of pins & needles in arms
- ☐ Sensation of pins & needles in fingers
- ☐ Fingers go to sleep
- ☐ Hands cold
- ☐ Swollen joints in fingers
- ☐ Sore joints in fingers
- ☐ Arthritis in fingers
- ☐ Loss of grip strength

CHEST:
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Pain around ribs

HIPS, LEGS & FEET:
- ☐ Pain in buttocks (R-L)
- ☐ Pain in hip joint (R-L)
- ☐ Pain down leg (R-L)
- ☐ Pain down both legs
- ☐ Leg cramps
- ☐ Pins & needles in legs (R-L)
- ☐ Numbness of leg (R-L)
- ☐ Numbness of feet (R-L)
- ☐ Numbness of toes
- ☐ Feet feel cold
- ☐ Cramps in feet (R-L)
- ☐ Swollen ankles (R-L)
- ☐ Swollen feet (R-L)
- ☐ Painful joints in toes
- ☐ Pain in foot (R-L)
- ☐ Pain in knee (R-L)

GENERAL:
- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Generally feel run-down
- ☐ Loss of sleep
- ☐ Loss of weight



MARK AREAS OF PAIN ABOVE

Have you had X-rays before? ☐ Yes ☐ No When? _____

What areas were X-rayed? _____

WOMEN ONLY: Date of last period? _____

☐ Menstrual pain ☐ Cramping ☐ Irregularity

Are you now pregnant? ☐ Yes ☐ No How long? _____

Purpose of this appointment: _____

Have you seen other doctors for this condition? ☐ Yes ☐ No

If So: Name _____ Date _____

Date of accident/illness _____ Hour _____ AM _____ PM Location: _____

How did accident occur? ☐ Auto Collision ☐ On-the-Job ☐ Other _____

Please describe the circumstances _____

_____

_____

Have you lost time from work? ☐ Yes ☐ No

Prior surgery _____

Medications taken presently _____

Previous accidents (other than described above) _____

_____

Parents living? ☐ Yes ☐ No In good health? ☐ Yes ☐ No