NT CHIROPRACTIC

Thank you for choosing our office! In order to serve you properly, we need the following information. PLEASE PRINT. All information will be confidential.

Date ____________ Patient Name ____ Patient # ___________
First MI Last

SS #/SIN ___________ ☐ Male ☐ Female Birthday ______________ Home Phone ___________

Address __________________________City ____________ State/Prov. ________ Zip/P.C. ___________

Email address ________________________________ Cell Phone ____________________

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or parents/guardian's employer _____________________________ Work Phone _____________

Business address _______________________ City _________ State/Prov. _______ Zip/P.C. ___________

Spouse or Parents /guardian's name ___________________ Employer ___________ Work Phone ________

If patient is a student, Name of school/college ____________________ City ______ State/Prov. _________

Whom may we thank for referring you? ____

Person to contact in case of emergency __________________________________ Phone ________________

In case of a medical emergency, if patient is of school age 15+, it is alright to treat in my absence.

X______________________________________ ________________________

Patient or guardian signature Date

RESPONSIBLE PARTY

Name of person responsible for this account __________________ Relationship to patient ____________

Address ____ Home Phone _____________________

Birthdate __________ Email ______________________________ Cell Phone ____________________

Employer ____ Work Phone __________________________

Is this person currently a patient at our office? ☐ Yes ☐ No

INSURANCE INFORMATION

Name of insured ____________________________________ Relationship to patient _________________

Birthdate ______________________ SS #/SIN _________________ Date employed ________________

Name of employer ________________________________ Work Phone ____________________________

Address of employer _______________ City __________________ State/Prov. ____ Zip/P.C. ________

Insurance Company __________________________ Policy # _________________ Group # ____________

Ins Co address ________________ City ___________ State/Prov. ______ Zip/P.C. ________

How much is your deductible? _______ how much have you used? _______ Max. Annual benefit? _______

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of insured ____________________________________ Relationship to patient _________________

Birthdate ______________________ SS #/SIN _________________ Date employed ________________

Name of employer ________________________________ Work Phone ____________________________

Address of employer _______________ City __________________ State/Prov. ____ Zip/P.C. ________

Insurance Company __________________________ Policy # _________________ Group # ____________

Ins Co address ________________ City ___________ State/Prov. ______ Zip/P.C. ________

How much is your deductible? _______ how much have you used? _______ Max. Annual benefit? _______

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X______________________________________ ________________________

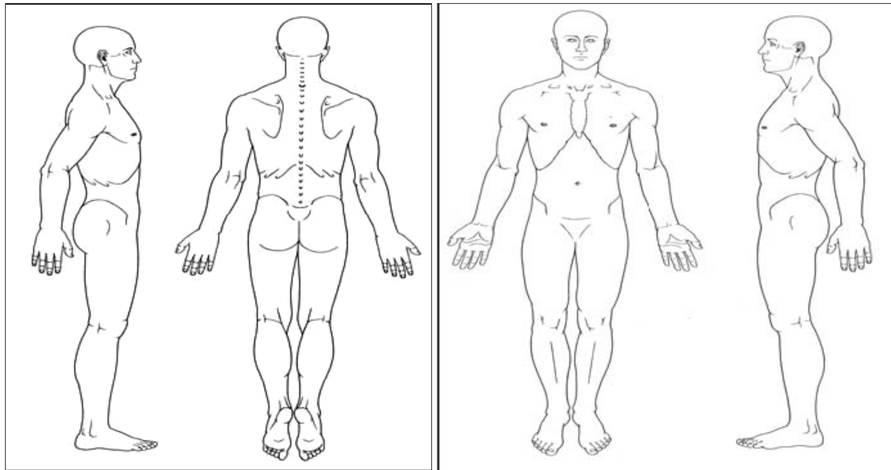
Patient or guardian signature Date

• 638 Londonderry • Denton, Texas 76205 • Phone 940-565-8118 • Fax 940-387-3070

Patient Name: ____________________ Date :_______________ ID #: ___________

Symptoms

Reason for visit _____________ When did you first notice the symptoms? __________
How did this complaint began? ____
Is this condition getting progressively worse? _________________________________
Where specifically is the problem(s) located? _________________________________
Which activities are difficult to perform? ___Sitting ___Standing ___ Walking ___ Bending ___Lying down ___Other
Type of Pain: ___Sharp ___ Dull ___ Throbbing ___ Numbness ___ Aching ___ Shooting ___ Burning ___ Tingling ___ Cramps ___ Stiffness ___ Swelling ___ Other
Please mark all areas where you feel symptoms.



Rate of severity of your pain (1, mild pain or discomfort, to 10 severe pain):
1 2 3 4 5 6 7 8 9 10
Is the pain constant or does it come and go? _______________________________
Does anything aggravate the complaint? ___________________________________
Does anything make it better? ____
Previous illnesses you've had in your life? _____________________________
Previous injury or trauma? ____
Have you ever received Chiropractic Care? ___ Yes ___ No If yes, where? __________
What treatment have you already received for your condition?
___Medication ___ Surgery ___ Physical Therapy ___ other ____________________
Name and address of other doctor(s) who have treated for your condition: ____
____
Date of Last Exams: ____
(Women) Are you pregnant? ___ Yes ___No Nursing? ___Yes ___ No
Taking birth control pills? ___ Yes ___ No
List any types of surgeries which you have had and the dates which they occurred: ____
____
____
Please list all medications you are currently taking: ____
Allergies: ____

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Patient Name: ____________________ Date :______________ ID #: __________

Family Health History:
Associated health problems of relatives ___________________________________
____

Daily Habits
What type of exercise do you perform on a daily basis? __ None __ Moderate __ Heavy
What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work)
____
What vitamins do you currently take? ____
What kind of other nutritional supplements do you take (if any)? ___________________
Do you smoke? ___ No ___ Yes How much per day? ___________________________
How much liquor do you consume on a weekly basis? __________________________
How much coffee or caffeinated beverages do you consume on a daily basis? _______

Authorization
The patient agrees to comply with OFFICE POLICY which includes all responsibility for payment for services provided in this office for my self or my dependents is mine, due and payable at the time services are rendered unless other arrangements are made in advance. In the event payments are not received by the agreed upon dates, I understand that 1 ½ % finance charge (18%) APR may be added to my account. I agree to pay an attorney and collection fees if this account is turned over for collection. X-rays remain the property of this clinic. Data from patient's treatments (excluding patient's names) may be used for research purpose.

____
SIGNATURE OF PATIENT (or parent if a minor) Date

____
SIGNATURE OF DOCTOR Date

Patient Name: ____________________ Date :______________ ID #: __________

General Questions
___ Weight Loss
___ Weight Gain
___ Change in Sleep
___ Change in activity

Neurological and Psychiatric
___ Anxiety
___ Headaches
___ Depression
___ Meningitis
___ Paralysis
___ Seizure
___ Stroke
___ Tingling
___ Tremors
___ Memory Loss
___ Fainting spells
___ Dizziness
___ Head injuries
___ Blackouts
___ Change in sensation anywhere on your body
___ Weakness or numbness

Musculoskeletal
___ Anemia
___ Arthritis
___ Back pain
___ Bursitis
___ Gout
___ Neck pain
___ Abn. Blood counts
___ Blood clots
___ Bone marrow Biopsy
___ Easy Bleeding
___ Easy bruising
___ Joint swelling
___ Morning stiffness
___ Muscle aches
___ Tendonitis

Respiratory
___ Asthma
___ Breathlessness when lying flat
___ Prolonged cough
___ Coughing up blood
___ Emphysema
___ Shortness of breath
___ Tuberculosis
___ Pneumonia
___ Frequent bronchitis
___ Wheezing

Ears, Eyes, Nose & Throat
___ Glaucoma
___ Polyps
___ Allergy
___ Cataracts
___ Double vision
___ Gum problems
___ Eye problems
___ Ear infections
___ Glasses/contacts
___ Hearing loss
___ Ear discharge
___ Frequent nosebleeds
___ Sinus infections
___ Swollen glands

Cardiovascular
___ Chest pain
___ Murmurs
___ Leg cramps
___ Ankle swelling
___ Cardiac catheterization
___ Cold hands/feet
___ Cong. heart defects
___ Dizziness when standing
___ Heart attacks
___ Heart failure
___ High/low BP
___ Irregular heart rate
___ Purple fingers/lips
___ Leg pain that resolves with rest
___ Heart palpitations
___ Varicose veins

Endocrine
___ Diabetes
___ Abn. body hair
___ Sickle cell
___ Change in skin texture
___ Cold intolerance
___ Heat intolerance
___ History of "borderline" diabetes
___ Increased loss of hair
___ Rheumatism
___ Thyroid disease

Gastrointestinal
___ Diarrhea
___ Gallstones
___ Reflux
___ Ulcers
___ Heartburn
___ Indigestion
___ Vomiting
___ Hepatitis
___ Abdominal pain
___ Anal fissures
___ Black tarry stools
___ Vomiting blood
___ Constipation
___ Nausea
___ Problems swallowing
___ Hiatal hernia
___ Intestinal obstruction
___ Liver disease
___ Hemorrhoids
___ Red blood after bowel movement

Skin
___ Abscess
___ Acne
___ Boils
___ Hives
___ Lumps
___ Jaundice
___ Athlete's foot
___ Excessive odor
___ Excessive sweating
___ Fungal infections
___ Nail problems
___ Moles Irregular
___ Moles Change/new
___ Dandruff
___ Oily/Dry skin
___ Rashes
___ Psoriasis

Kidney & Urinary Tract
___ Blood in urine
___ Brown Urine
___ Painful urination
___ Excessive thirst
___ Involuntary Urination/incontinence
___ Urination frequent
___ Urine hesitancy
___ Weak flow
___ Bladder infections
___ Kidney disease
___ Kidney stones

Females only
___ D & C
___ Hernia
___ Abn. Bleeding between cycles
___ Abn. pap smear
___ Bleeding after intercourse
___ Complications w/pregnancy
___ PMS
___ Endometriosis
___ Heavy bleeding during cycles
___ Discharge from breast
___ Ovarian Cysts
___ Hot flashes
___ Fibroids
___ Pelvic inflammatory disease
___ Postmenopausal symptoms
___ Vaginal discharge
___ Vaginal Dryness

Males only
___ Hernia
___ Bloody ejaculation
___ Inability to complete intercourse
___ Lump on testicle
___ Penile discharge
___ Problems maintaining
___ Prostate disease
___ Sores on penis or warts
___ Sterility
___ Testicular pain
___ Testicular swelling

Male & Female
___ Painful sexual intercourse
___ Loss of sexual interest
___ Unprotected sex
___ Groin itching
___ Sexually transmitted diseases

Abn. = Abnormal