NATURAL HEALTH FAMILY CHIROPRACTIC
103 Sharlene Road
Ithaca, New York 14850
(607) 277-1468

New Patient Information

Name (full name please) _____ Date _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Home Phone _____ Cell Phone_____

Email Address_____ Would you like reminders for future appointments? Yes ❑ No ❑

Employer _____ Work Phone _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Student Status _____ Ages of Children _____ Referred By _____

Marital Status: S M D W Sep Name of Spouse/Partner_____

Name & Phone of person to contact if we cannot reach you _____

Have you had chiropractic care before? Yes ❑ No ❑ DC's Name _____

The practice of chiropractic is based upon the location and adjustment of vertebral subluxations. These spinal subluxations are caused by any stress to which your body cannot adapt. These stresses may by **physical**, **chemical**, or **emotional** in nature.

Health History

Were there any problems associated with your mother's pregnancy or your birth? _____

_____

Do you have any congenital disorders? _____

Did you have any childhood illnesses or injuries? _____

Have you had any illnesses or injuries that required hospitalization or surgery? _____

_____

Do you have any chronic illnesses? _____

Have you had any sports or auto accident related injuries or trauma? _____

_____

Are you taking any medications? What for? _____

_____

Lifestyle and Habits - Please list amounts of each

Coffee/Caffeine _____ Alcohol _____ Non-caffeinated fluids/Water _____

Tobacco _____ Exercise _____ Sleep _____

(over please)

History of Concern

Reason for contacting us _____ Date of onset _____

How did symptoms start? *Sudden* *Gradual* Are symptoms - *Constant* *Intermittent* *Occasional*

Initiating factors _____

What makes the concern better? _____

What makes the concern worse? _____

Has this interfered with your daily activities? In what way? _____

What do you believe caused this concern? _____

Is this concern job or auto accident related? _____

Payment and Insurance Information

Payment is expected at the time of each visit.

If you are intending to submit any claims for reimbursement to an insurance company, please read and sign this. Additionally, if you will be filing a **Workers' Compensation** claim or a **No Fault** (auto accident) claim, please fill out the appropriate questionnaire.

I, _____ am responsible for payment and I understand and agree that health and accident insurance policies are arrangements between an insurance carrier and myself. I understand that **Natural Health Family Chiropractic** will complete the appropriate part of any necessary forms and provide any required reports to assist me in making collections from an insurance company. I understand that any amount paid to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment.

Please fill in information as completely as possible so insurance claims are accurate.

Name of policy holder _____Relationship to patient _____

Policy holder's address (if different from patient's) _____

Phone# _____ Date of birth _____

Policy holder's employer (and address) _____

_____

Insurance Company _____ Insured's ID number_____

Insurance Company's address _____

_____

Insurance Company's Phone # _____ Fax# _____