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.

Pregnancy History

How many pregnancies have you had (excluding present one)? _____

How many live births? _____ Delivered at? _____

Briefly describe all previous pregnancies and deliveries. _____

_____

Were there any difficulties or irregularities of your menses? _____

Were there any difficulties getting pregnant? _____

Who is involved with this pregnancy? Midwife _____ OB _____

Labor support _____

What is the probable due date of this pregnancy? _____

How has your general health been during this pregnancy? _____

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? _____

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 per week

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

Tobacco _____ Exercise _____ Sleep _____

Additional Information

_____

_____

_____

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.

_____
Signature

Please fill in information as <u>completely</u> as possible so insurance claims are <u>accurate</u>.

Name of policy holder _____ Relationship to patient _____

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

Phone# _____ Date of birth _____ SS# _____

Policy holder's employer (and address) _____

_____

Insurance Company _____ Insured's ID number _____

Insurance Company's address _____

_____

Insurance Company's Phone # _____ Fax# _____