New Patient Welcome Form

Patient Information

Date_____ **Date of Birth**_____

Patient Name_____
First **M** **Last**

What do you prefer to be called? _____

Address _____

City _____ **State** _____ **Zip** _____

Patient SSN#_____

□ **Male** □ **Female** **Language** (If other than English)_____

Ethnicity (Mark one) □ **Hispanic or Latino** □ **Not Hispanic or Latino**

Race (Mark one or more) □ **American Indian or Alaska Native** □ **Asian** □ **White** □ **Black or African American** □ **Native Hawaiian or Other Pacific Islander**

Reminder Text/Call regarding future appointment □ **Yes** □ **No**

Cell Phone_____ **Cell Phone Carrier**_____

Home Phone_____ **E-mail**_____

Occupation _____

Employer/ School_____

Employer/ School Address _____

City _____ **State** _____ **Zip** _____

Employer/ School Phone_____

If Minor, Parent/Legal Guardian's Name_____

□ **Married** □ **Single** □ **Widowed** □ **Divorced** □ **Separated**

Spouse's Name_____

Spouse's Cell Phone _____

Spouse's Employer _____

How did you hear about us?_____

Health Insurance

Do you have a Flex Spending (FSA) or Health Savings (HSA) Account? □ **Y** □ **N**

Insurance Company_____

Policy # _____**Group #**_____

Relationship to the patient □ **Self** □ **Spouse** □ **Child** □ **Other**

* If you selected "self" please stop here and proceed to the next section.

Policy Holder _____
First **M** **Last**

Policy Holder's Date of Birth _____ **Sex** □ **Male** □ **Female**

Policy Holder's Address, City, State, Zip_____

Secondary Health Insurance

Insurance Company_____

Policy # _____**Group #**_____

Relationship to the patient □ **Self** □ **Spouse** □ **Child** □ **Other**

* If you selected "self" please stop here and proceed to the next section.

Policy Holder _____
First **M** **Last**

Policy Holder's Date of Birth _____ **Sex** □ **Male** □ **Female**

Policy Holder's Address, City, State, Zip_____

Emergency Contact

This must be someone NOT living in your household.

Name:_____**Relationship:**_____**Cell Phone:**_____ _____**Home Phone:**_____

Address:_____**City, State, Zip:**_____

Designation of Personal Representative

Name:_____**Relationship:**_____**Cell Phone:**_____ **Home Phone:**_____

Address:_____**City, State, Zip:**_____

I hereby designate the above named individual as my personal representative who may act on my behalf for the purpose of: Consenting to use and disclosure of my health information, authorizing use and disclosure of my health information, and receiving information that otherwise would be sent me. If I am incapacitated, my personal representative may also sign any form (such as authorization, revocation of authorization, request for access to information and/or billing inquiries), the uses of which are described in privacy policies and procedures. I understand that a person who is identified in my medical record as having medical power of attorney or other legal authority to act on my behalf is additionally recognized as my personal representative. I understand that I have the right to revoke this authorization at any time. Revoking this authorization must be made in writing, signed, and dated.

Authorization and Medical Release

I affirm that the above information is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my medical status. I authorize the doctor to treat my condition as he deems appropriate and to grant full disclosure for all previous or concurrent care. I agree to grant full indemnity to Alternative Wellness & Chiropractic Center and it's physicians for complications related to all pre-existing conditions medically diagnosed or otherwise not disclosed.

Patient or Guardian Signature_____ **Date** _____

Print Guardian Name _____ **Relationship to Patient** _____

ALTERNATIVE WELLNESS
& CHIROPRACTIC CENTER

Name:_____

I. HEALTH HISTORY

Do you smoke?* ☐ Y ☐ N ☐ Social ☐ Quit

Current Medication:*_____

_____

☐ I will provide a list of my medications.

Allergies:*_____

_____

Medication Intolerance:*_____

_____

Name of Pediatrician and Other Doctors: _____

Date of Last Visit _____/_____/_____ Reason:_____

Complications During Pregnancy: ☐ No ☐ Yes Explain:_____

Ultrasounds During Pregnancy: ☐ No ☐ Yes How Many:_____

Medication During Pregnancy / Delivery ☐ No ☐ Yes List:_____

Cigarette/Alcohol Use During Pregnancy ☐ No ☐ Yes

Has any Doctor/Professional advised you to "Take the child to a Chiropractor": ☐ No ☐ Yes Name: _____

Please describe any past conditions and treatment received: _____

_____

Please list any past hospitalizations and surgeries: _____

_____

Family History

Father's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other_____

Mother's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other_____

Is there any other family history you want us to know?_____

II. REVIEW OF SYSTEMS

(Check all that apply)

Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	Vision Problems
☐	☐	Ear Infections	☐	☐	Sleeping Problems
☐	☐	Colic	☐	☐	Growing Pains
☐	☐	Allergies / Asthma	☐	☐	Dental Problems
☐	☐	Medication Side Effects	☐	☐	Temper Tantrums
☐	☐	Recurring Fevers	☐	☐	ADHD
☐	☐	Digestive problems	☐	☐	Scoliosis
☐	☐	Chronic Colds/Sinus	☐	☐	Ever Needed Stitches
☐	☐	Other_____			

III. REASONS FOR SEEKING CARE

Present Complaints

1. _____**How long has this been an issue?**_____
Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb/Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in morning ☐ Worse in evening ☐ Pain radiates to_____

2. _____**How long has this been an issue?**_____
Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb/Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in morning ☐ Worse in evening ☐ Pain radiates to_____

3. _____**How long has this been an issue?**_____
Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb/Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in morning ☐ Worse in evening ☐ Pain radiates to_____

4. What makes it better?_____

5. What makes it worse?_____

6. What Doctor's have you seen for this?_____

7. Type of treatment:_____

8. Results:_____

Rate your pain 0 to 10, ten being the worst

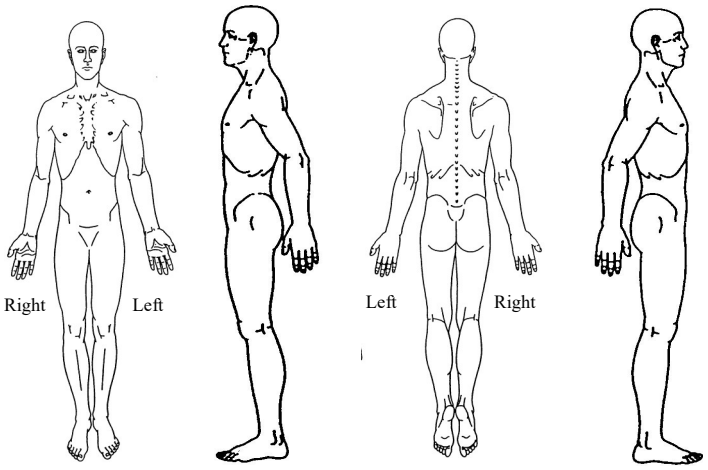
Neck Pain
0 1 2 3 4 5 6 7 8 9 10

Mid Back Pain
0 1 2 3 4 5 6 7 8 9 10

Low Back, Hip Pain
0 1 2 3 4 5 6 7 8 9 10

Other Pain _____
0 1 2 3 4 5 6 7 8 9 10

Mark <u>ALL</u> areas of pain on figures below



IV. CERTIFICATION

I certify that I have read and understand the above information. I acknowledge that I have answered the above questions correctly and to the best of my ability. I will not hold my chiropractor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient/Guardian Signature_____ Date _____

(Office Use Only)

The above health history questionnaire was reviewed by _____(Physician) Date _____