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New Patient Application

Name:____ *Date*:_____________
(First) (Middle) (Last)

Date of Birth: _____/______/________ *Sex:* __ *M* __ *F*

*Home Address:*_________________________________*City:*_________________*St:*____*Zip:*__________

HomePhone:_____________________*WorkPhone*:______________________*CellPhone*:______________________

Email Address: ____

Student Status: ___*FT* ___*PT* *Employment Status:* ___*FT* ___*PT* *Marital Status:* ___ *S*___*M*___*D*

Spouse's Name: ________________________________*Best Contact Number:*______________________

*Emergency Contact:*____*Phone:*_____________________

How did you learn about our clinic? ____

*Were you referred by anyone? If so, please name:*____

May we send you clinic updates? (ie: upcoming seminars, newsletter) ___ *yes* ___ *no*

Payment Information

I will be paying today by: ☐ Cash ☐ Check ☐ Credit Card ☐ Auto Ins ☐ Workers Comp Ins

I authorize NeuroTarget Chiropractic, LLC to release any medical or other information necessary to process this claim. I request payment of medical benefits from either a government or non-government source to NeuroTarget Chiropractic, LLC. I authorize NeuroTarget Chiropractic, LLC to initiate a complaint to the Insurance Commissioner on my behalf. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I further understand that I will be legally responsible for all collection costs involved with the collection of this account including court costs, reasonable attorney fees and all other expenses incurred with collections, if I default on this agreement. In addition, if I issue a check that is returned by the bank for non-sufficient funds, I understand I will be charged $30.00 for each returned check. If I choose to use my non-contract insurance company, I will be considered a cash patient by NeuroTarget Chiropractic, LLC. Payment for professional services are due at the time of service. After paying in full I will receive a receipt with the appropriate billing and diagnosis codes to submit to my insurance company myself by following the directions on the back of my insurance card. My insurance company will reimburse me directly. I certify the information above is true and correct to the best of my knowledge.

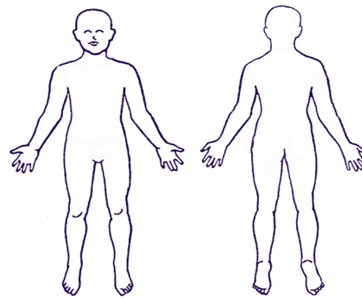
Signature: ____ Date:________________________________

Name: ________________________ DOB: _____________

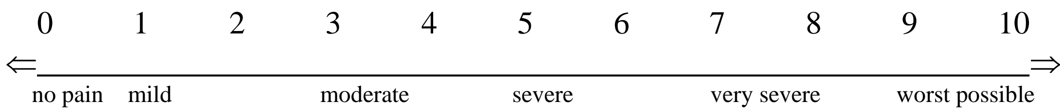
Chief Complaint – Present Condition

What is bringing you to the office today? ____
____
When did your complaints and/or symptoms begin? _____________________________________
What caused the onset of your condition? ____
Describe the condition (ache, sharp, burn, tight)?_____________________________________
Is your condition ☐ improved ☐ worsening ☐ staying the same since the onset?
What makes your condition worse? ____
What helps your condition? ____
How often or when does your condition occur? _______________________________________
Does your condition radiate or affect other areas? ____________________________________
Have you had this condition before? ____
Is your condition interfering with: ☐ sleep ☐ work ☐ daily activities ☐ other ______________
Have your received treatment for this condition? _____________________________________
Please mark your symptoms on the diagram.

Aching – XXX
Burning - ###
Numbness - ///
Pins/Needles – 000
Stabbing - •••



Rate your pain right now (mark as "N"); worst (mark as "W"); best (mark as "B")



Please check all present symptoms related to your <u>current</u> condition:

Head & Face

☐ base of skull ☐ side/temple ☐ nausea/vomiting ☐ ear pain ☐ throbbing ☐ migraine
☐ incapacitating ☐ front ☐ ringing in ears ☐ nose bleeds ☐ eyelids heavy ☐ top
☐ double vision ☐ pressure ☐ head feels heavy ☐ eye pain ☐ jaw pain ☐ flushing
☐ light sensitive ☐ blurry vision ☐ headache affects vision ☐ dizziness ☐ sinus problems

Neck

☐ weakness ☐ spasms ☐ pain on motion ☐ limited motion ☐ pain ☐ swelling
☐ lumps ☐ throat tight ☐ radiating pain ☐ difficulty swallowing ☐ stiffness

Shoulder, Arm & Hand

<u>Shoulder</u>: ☐ local pain ☐ limited movement ☐ pain on movement ☐ pain from neck ☐ radiates down arm
<u>Arm & Hand</u>: ☐ local pain ☐ pain on movement ☐ swelling ☐ cold hands ☐ weakness
☐ radiates from neck ☐ numbness/tingling ☐ cannot raise arm

Mid-back & Low-back

☐ weakness ☐ pain ☐ spasms ☐ rib pain ☐ chest pain ☐ stiffness ☐ swelling ☐ pain on motion
☐ limited motion ☐ radiating pain

Hips, Legs, Knees and Feet

☐ local pain ☐ radiating ☐ from back ☐ down leg ☐ swelling ☐ numbness ☐ tingling ☐ spasms
☐ cramping ☐ cold feet ☐ weakness ☐ pain on motion ☐ varicose veins

Name: ________________________ DOB: ______________

Nerves

☐ burning ☐ numbness ☐ tingling ☐ tremor ☐ dizziness ☐ loss of balance ☐ loss of consciousness
☐ coordination ☐ twitching ☐ difficulty with memory ☐ seizures ☐ generalized weakness

Sleep

☐ good ☐ fair ☐ poor ☐ poor due to pain ☐ deep burning pain
☐ difficulty falling asleep ☐ difficulty staying asleep ☐ wake often

Fatigue

☐ must rest during day ☐ cannot get enough rest ☐ intermittent fatigue ☐ constant fatigue
☐ worse with exercise ☐ mental fatigue ☐ physical fatigue

Past Medical History

Please mark any of the following that you have experienced in the ***past 6 months***

General

☐ weight loss ☐ weight gain ☐ night sweats ☐ change in appetite ☐ chills
☐ fever ☐ insomnia ☐ fatigue ☐ itching ☐ spots on fingernails
☐ fragile/brittle nails ☐ headaches ☐ skin rash/sores ☐ excessive thirst ☐ bruise/bleed easily

Head, Eyes

☐ pain at base of skull ☐ pain on side of head ☐ temporal pain ☐ pain on top of head ☐ migraine
☐ vision loss ☐ blurred vision ☐ double vision ☐ poor night vision ☐ eye pain
☐ red eye

Ears, Nose and Throat

☐ ear pain ☐ ear discharge ☐ hearing difficulty ☐ ringing in ears ☐ earache/infections
☐ loss of smell ☐ nose bleeds ☐ nasal discharge ☐ post nasal discharge ☐ sinus pressure
☐ sinus congestion ☐ sore throat ☐ oral sores ☐ dental problems ☐ tooth pain
☐ bleeding in gums/lips ☐ hoarse voice ☐ neck pain

Cardiovascular and Respiratory

☐ chest pain/tightness ☐ palpitations ☐ swelling of legs/feet ☐ leg pain ☐ low blood pressure
☐ high blood pressure ☐ cold hands/feet ☐ irregular/fast heartbeat ☐ fainting ☐ varicose veins
☐ shortness of breath ☐ dizziness ☐ coughing blood ☐ lung problems
☐ persistent cough ☐ wheezing ☐ snoring ☐ light headed

Gastrointestinal

☐ nausea ☐ vomiting ☐ heartburn ☐ gas/bloating ☐ bloody stools
☐ bright red stools ☐ black tarry stools ☐ esophageal reflux ☐ constipation ☐ hemorrhoids
☐ ulcers ☐ diarrhea ☐ gallbladder problems ☐ bowel incontinence ☐ abdominal pain/cramps

Genitourinary

☐ pain with urination ☐ frequent urination ☐ kidney stones ☐ loss of bladder control ☐ infection
☐ wake to urinate ☐ blood in urine ☐ sexual dysfunction ☐ urgency with urination ☐ STD
☐ incomplete bladder emptying

Male/Female Systems

☐ prostate problems ☐ testicular pain ☐ swelling in the scrotum ☐ sexual dysfunction
☐ irregular periods ☐ vaginal pain/infection ☐ vaginal bleeding ☐ menopause ☐ menstrual cramps
☐ breast pain/lumps __ # of pregnancies __ # of live births __ # of C-Sections

Musculoskeletal

☐ joint pain ☐ muscle pain ☐ back stiffness ☐ joint stiffness ☐ back pain
☐ muscle stiffness ☐ joint swelling ☐ difficulty with limb movement

Name: ________________________ DOB: _____________

Skin

☐ new rashes/moles ☐ non-healing sores ☐ skin itch ☐ hair loss

Neurologic

☐ headache ☐ muscle weakness ☐ numbness ☐ coldness ☐ crawling/prickling
☐ memory loss ☐seizures/convulsions ☐ dizziness ☐ confusion ☐ paralysis

Psychiatric

☐ anxiety ☐ sadness ☐ irritability ☐ insomnia ☐ suicide

Endocrine

☐ heat intolerance ☐ cold intolerance ☐ excessive thirst ☐ excessive hunger

Hematologic/Lymphatic

☐ easy bleeding ☐ easy bruising ☐ bleeding disorder ☐ lymph node enlargement

Allergic/Immunologic

☐ hives ☐ seasonal allergies ☐ environmental allergies ☐ HIV exposure

Have you had an allergic reaction to the following?

☐ latex and rubber ☐ bee or wasp stings ☐ adhesive tape
☐ iodine or x-ray contrast dye ☐ influenza vaccination ☐ other: ________________________________

Do you have any food allergies? ☐ Yes ☐ No If yes, please list: ____
____
____

Have you ever been hospitalized? ☐ Yes ☐ No
If so, where and when? ____
____

Please list your surgery(ies)

Date	Type of Surgery	Results

Are you taking any medication? ☐ Yes ☐ No If yes, please complete table below:

Medication Name	Dosage	How Often Taken	How long have you been taking this medication?

Are there any medications you have had an allergic reaction or unpleasant side effects? ______________________
____

Are you currently taking any supplements? ☐ Yes ☐ No If yes, please complete table below:

Supplement Name	Dosage	How Often Taken	How long have you been taking this medication?

Name: ________________________ DOB: _____________

Personal and Family History

Have *you* ever suffered from or been diagnosed as having:

Condition	Response	Condition	Response
Broken or Fractured Bones	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Vascular Disease	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No
Rheumatoid Arthritis	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Seizures/Convulsions	☐ Yes ☐ No	Strokes	☐ Yes ☐ No
A Congenital Disease	☐ Yes ☐ No	Ruptures	☐ Yes ☐ No
Eating Disorder	☐ Yes ☐ No	Dizziness	☐ Yes ☐ No
Coughing Blood	☐ Yes ☐ No	HIV Positive	☐ Yes ☐ No
Speech Problems	☐ Yes ☐ No	Head Problems	☐ Yes ☐ No
Eye/Vision Problems	☐ Yes ☐ No	Tumors	☐ Yes ☐ No
Difficulty Breathing	☐ Yes ☐ No	Insomnia	☐ Yes ☐ No
Loss of Bowel Control	☐ Yes ☐ No	Diarrhea	☐ Yes ☐ No
Ear/Hearing Loss	☐ Yes ☐ No	Nervousness	☐ Yes ☐ No
Loss of Bladder Control	☐ Yes ☐ No	Constipation	☐ Yes ☐ No
Digestion Problems	☐ Yes ☐ No	Gallbladder	☐ Yes ☐ No
Thyroid disorder	☐ Yes ☐ No	Polio	☐ Yes ☐ No
Rheumatic fever	☐ Yes ☐ No	Chicken Pox	☐ Yes ☐ No
Sexually Transmitted Disease	☐ Yes ☐ No	Circulatory	☐ Yes ☐ No

Please mark the appropriate boxes to identify ALL illness or conditions, which you know have occurred in *you or your blood relatives*. Indicate "none" if you are unsure.

	Self	Mother	Father	Brothers	Sisters	Grandparents	None
Cancer	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Eczema/Psoriasis	☐	☐	☐	☐	☐	☐	☐
Migraine Headaches	☐	☐	☐	☐	☐	☐	☐
Seizure Disorder	☐	☐	☐	☐	☐	☐	☐
Stroke/TIA	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐
Abnormal Bleeding	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐
Alcohol/Drug Abuse	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐
Other Psychological/ Mental Illness	☐	☐	☐	☐	☐	☐	☐
Suicide (or attempted)	☐	☐	☐	☐	☐	☐	☐
Genetic Disorder	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐
Colon Polyp	☐	☐	☐	☐	☐	☐	☐
Hepatitis:	☐	☐	☐	☐	☐	☐	☐
Obesity:	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐

If any family member is deceased due to any of the conditions listed above, please list who and of what condition:

____

____

Name: ________________________ DOB: _____________

Social History

Are you currently married? ☐ Yes ☐ No In a relationship/partnership? ☐ Yes ☐ No
Have you been: ☐ Separated ☐ Divorced ☐ Widowed In that past year? ☐ Yes ☐ No

What is your current employment status?
☐ Full time ☐ Part time ☐ unemployed ☐ retired ☐ disabled
Occupation: _________________________

What are you current living arrangements?
☐ House ☐ Apartment ☐ Assisted Living ☐ Nursing Home ☐ Other ______________

Do you live: ☐ alone ☐ with spouse/family ☐ with others

Stress Screening:
☐ trouble dealing with stress ☐ stress induced digesting problems ☐ health feels out of your hands
☐ in therapy or counseling ☐ suicidal thoughts ☐ use food or alcohol to deal with stress

Do you find any dysfunction or concerns with:
☐ relationship with family ☐ relationship with friends ☐ intimate relationships
☐ career/work/school ☐ religious/spiritual path ☐ physical appearance

Substance Review:

Do you use tobacco? ☐ Yes ☐ No Pack per day _______# of years ________
Previously used? ☐ Yes ☐ No

Do you use Alcohol? ☐ Yes ☐ No Servings per day _____ Days per week ______ # of years______
Previously used? ☐ Yes ☐ No

Do you use Caffeine? ☐ Yes ☐ No Servings per day _____ Days per week _____ # of years _____

Self-Care/Home Environment Assessment:

In an average week, how many minutes of moderately vigorous physical activity do you get?
☐ none ☐ 1-30 ☐ 31-60 ☐ 61-120 ☐ 121-180 ☐ 181-240 ☐ 241-300 ☐ 300+

Do you have any special dietary needs or food sensitivities? ☐ Yes ☐ No
If yes, please list:____
____

How many servings of fruit do you have in a typical day? ☐1 ☐2 ☐3 ☐4 ☐5 ☐6+

Describe your typical breakfast: ____

Describe your typical lunch: ____

Describe your typical dinner: ____

Do you snack? ☐ Yes ☐ No
If yes please list your typical snacks:____

Name: ________________________ DOB: _____________

History of Care (Current Condition)

Primary Medical Physician: ____ Phone: _____________________
Primary Clinic Name/Location:____

Do you have medical records that have been created or have you seen another doctor because of your current condition? ☐ Yes ☐ No
If so, please list the doctors that have seen you for your current complaint.

1. Name: __________________________ Phone: _________________ City/State: __________________________

2. Name: __________________________ Phone: _________________ City/State: __________________________

3. Name: __________________________ Phone: _________________ City/State: __________________________

Have you had any diagnostic tests performed by the aforementioned doctors or any other Doctors? ☐ Yes ☐ No
If so, please check the tests you may have had performed:
☐ MRI ☐ X-Ray(s) ☐ Lab Work ☐ Functional Testing ☐ Psychological Testing
☐ Electro-diagnostics ☐ Other(s) ______________________

To help the doctor determine your needs, please indicate your specific interests:

☐ Chiropractic Adjustments
☐ Neurological Evaluation
☐ Nutritional Counseling (recommendations)
☐ Dietary Counseling (recommendations)
☐ Exercise Consultation
☐ Life Style Coaching

Upon signature of this document I am certifying that all the information provided is true, correct and complete. If more information about my illness becomes known, I will tell the doctor when possible so that it can be added to my record.

Patient Signature: ____ Date: _______________

Parent or Guardian Signature: ______________________________ Date: _______________
(please sign, print your name and relationship to the patient)