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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*:_________________

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:*____

Email Address: ____

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: _____________

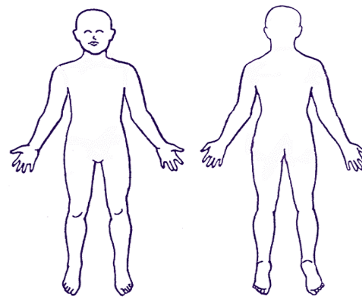
Chief Complaint – Present Condition

What is bringing you to the office today? ____

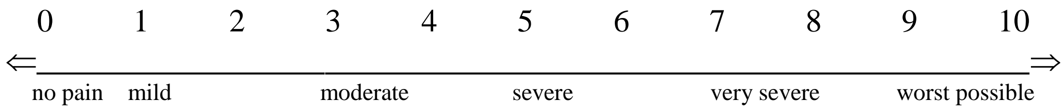
____

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

Name: ________________________ DOB: _____________

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

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?

Name: ________________________ DOB: _____________

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?

Personal and Family History

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

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	☐	☐	☐	☐	☐	☐	☐

Name: ________________________ DOB: _____________

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:

____

____

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

Name: ________________________ DOB: _____________

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:____

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)