

New Patient Health History

In order to provide you the best possible wellness care, please complete this form and bring it to your first appointment.
All information is strictly CONFIDENTIAL.

Date: _____

Patient Information

Patient Name _____ Male ___ Female ___
Street _____ City _____ State _____ ZIP _____
Telephone (work) _____ (ext.) _____ (home) _____ (mobile) _____
Best time and place to reach you: _____ Referred by _____
Age _____ Birth Date ____/____/____ SSN _____ - _____ - _____ Ages of children, if any _____
Occupation _____ Employer _____
Employer's Address _____ Marital Status _____

Spouse Information

Name _____ Birth Date ____/____/____ SSN _____ - _____ - _____
Phone _____ Occupation _____ Employer _____

Current Health Complaints

Nature of Injury ___Automobile* ___Work ___Other Please describe _____

Date of Injury ____ - ____ - ____ Date Symptoms Appeared ____ - ____ - ____

Have you ever had the same condition? ___Yes ___No If yes, when? _____

List of practitioners seen for this injury/condition _____

Have you ever been under chiropractic care? ___Yes ___No

If yes, please describe _____

Insurance Information

Name of party responsible for payment _____ Phone _____

Relationship to patient _____

Do you have health insurance? ___Yes ___No Name of Company _____

*If an auto accident, please provide:

Insurance Co. Name _____ Contact Person _____

Phone _____ Claim No. _____

Billing

Name of Insured _____. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and me. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

Emergency Info

Emergency Contact _____ Relationship _____ Phone _____

Medical History

Have you been treated for any conditions in the last year? No Yes

If yes, please describe _____

Date of last physical exam _____ Is there a chance that you are pregnant? No Yes

Have you had X-rays taken? No Yes If yes, where? _____

What medications are you taking and for what conditions (Please list dosage and amounts, etc). _____

What vitamins, minerals, or herbs do you currently take? (Please list for what condition, dosage, and frequency). _____

Have you ever:	No	Yes	Briefly Explain
Broken bones?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been in an auto accident?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had Sprains/Strains?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been struck unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Family History

Family Member	Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Habits:	None	Light	Moderate	Heavy		Yes	No
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you experience pain every day?	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do your symptoms interfere with daily life?	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does pain wake you up at night?	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are your symptoms worse during certain times of the day?	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do changes in weather affect your symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear orthotics?	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you take vitamin supplements?	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What activities aggravate your symptoms?		
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Sugary Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		

Have you ever suffered from:

- Alcoholism
- Allergies
- Anemia
- Arteriosclerosis
- Arthritis
- Asthma
- Back Pain
- Breast lump
- Bronchitis
- Bruise Easily
- Cancer
- Chest Pain/Conditions
- Cold extremities
- Constipation
- Cramps
- Depression
- Diabetes
- Digestion Problems
- Dizziness
- Ears Ring
- Excessive Menstruation
- Eye Pain/Difficulties
- Fatigue
- Frequent Urination
- Headache
- Hemorrhoids
- High Blood Pressure
- Hot Flashes
- Irregular Heart Beat
- Irregular Cycle
- Kidney Infection
- Kidney Stones
- Loss of memory
- Loss of balance
- Loss of smell
- Loss of taste
- Lumps In Breast
- Neck Pain or Stiffness
- Nervousness
- Nosebleeds
- Pacemaker
- Polio
- Poor Posture
- Prostate Trouble
- Sciatica
- Shortness of breath
- Sinus Infection
- Sleep problems/insomnia
- Spinal Curvatures
- Stroke
- Swelling of ankles
- Swollen Joints
- Thyroid Condition
- Tuberculosis
- Ulcers
- Varicose Veins
- Venereal Disease
- Other:

Current Complaints (Continued)

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache
B=Burning
N=Numbness

O=Other
P=Pins & Needles
S=Stabbing

Rate each area of pain:
1=least
10=highest

The form contains five anatomical diagrams for pain rating. At the top are two full-body diagrams: one showing the front view of a male torso and one showing the back view. Below these are two side-view diagrams of a human head and neck, showing the profile of the head and the neck muscles. At the bottom is a side-view diagram of a human arm and hand, showing the muscles of the forearm and the hand.

**Patient fill out
bottom box only**

DYER CHIROPRACTIC CLINIC
33 East County Line Road, Greenwood, IN 46143
www.DyerChiropractic.com
Phone (317) 882-4922 Fax (317) 882-4898

PATIENT REQUEST FOR RECORDS

For office use only:

DATE: _____

TO: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

I hereby authorize the release of: _____ All Medical records
_____ X-rays
_____ Blood work results
_____ MRI results
_____ Other _____

_____ Please **MAIL** records to: _____ **Dyer Chiropractic Clinic**
33 East County Line Rd
Greenwood, IN 46143

or

_____ Please **FAX** records to: _____ **FAX: 317-882-4898**

Patient please fill out this section:

Patient's Printed Name: _____

Birthdate: _____ Social Security Number: _____

Patient's Signature: _____

Assignment and Instruction for Direct Payment to Doctor Private and Group Accident and Health Insurance

I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to:

DYER CHIROPRACTIC CLINIC
33 East County Line Road
Greenwood, IN 46143

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

33 East County Line Road
Greenwood, IN 46143

The professional or chiropractic expense benefits allowable and otherwise payable to me under my current insurance policy are payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any Insurance company, adjuster, or attorney involved in this case.

Dated this _____ day of _____, 20_____.

Signature of Policyholder

Signature of Claimant, if other than Policyholder

Name: _____ Date: _____

Please list any and all doctors seen in the last two years:

Doctor: _____

Address: _____ (if known)

Phone: _____

Reason for visit / treatment:

Doctor: _____

Address: _____ (if known)

Phone: _____

Reason for visit / treatment:

Doctor: _____

Address: _____ (if known)

Phone: _____

Reason for visit / treatment:

(Please print this form again if you need more space)

