Ringer Chiropractic Clinic

NEW PATIENT INFORMATION

Patient Name _____ Birthdate _____ SSN _____

Address _____ Email _____

City _____ State _____ Zip _____ Cell/Home Phone _____

Occupation _____ Employer _____ Work Phone _____

Address _____ City _____ State _____ Zip _____

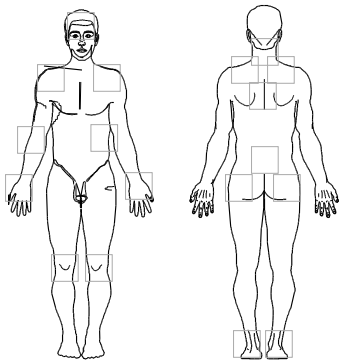
Health Plan _____ Subscriber Name _____

Subscriber ID # _____ Group # _____ Spouse Name _____

Spouse Employer _____ City _____ State _____ Zip _____

Primary Care Physician Name _____ PCP Phone _____

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain

☐ Other _____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began _____

How Problem Began

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

How often are your symptoms present?

(Occasional) ☐ 0 - 25% ☐ 26 - 50% ☐ 51 - 75% ☐ 76 - 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken _____ **What areas were taken?** _____

Please check all of the following that apply to you:

- ☐ Alcohol/Drug Dependence
- ☐ Recent Fever
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Stroke (Date) _____
- ☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
- ☐ Taking Birth Control Pills
- ☐ Dizziness/Fainting
- ☐ Numbness in Groin/Buttocks
- ☐ Cancer/Tumor (Explain) _____
- ☐ Osteoporosis
- ☐ Epilepsy/Seizures
- ☐ Other Health Problems (Explain) _____
- ☐ Prostate Problems
- ☐ Menstrual Problems
- ☐ Urinary Problems
- ☐ Currently Pregnant, # Weeks _____
- ☐ Abnormal Weight ☐ Gain ☐ Loss
- ☐ Marked Morning Pain/Stiffness
- ☐ Pain Unrelieved by Position or Rest
- ☐ Pain at Night
- ☐ Visual Disturbances
- ☐ Surgeries _____
- ☐ Tobacco Use - Type _____ Frequency _____/Day
- ☐ Medications _____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature _____ **Date** _____