

Welcome to North Lakes Chiropractic

New Patient Information

Name: _____ Date: _____
First Last MI

I prefer to be addressed as: _____ Birthdate: _____ Male/Female

Address: _____ City: _____ State: ___ ZIP: _____

Primary Phone: _____ Work/Cell/Other Phone: _____

e-mail: _____ Contact Preferences (circle): phone e-mail text

How did you hear about us? _____

Occupation: _____ Employer: _____

Marital Status: Single Married Divorced Widowed Partnered

Spouse/Partner Name: _____ Children? Yes/ No How Many? _____

Preferred Language: English Spanish Other: _____ Race: _____

Ethnicity (circle): Hispanic or Latino NOT Hispanic or Latino

About Today's Visit

The reason for this visit: _____

Please describe pain and location: _____

When did it begin? _____ Is it getting worse? Yes No Constant Comes/goes

Does it interfere with your daily routine? Yes No If yes, please explain _____

Have you had similar symptoms in the past? Yes No If yes, please explain _____

Have you been treated by a chiropractor previously? Yes No

If yes, whom? _____ Address or phone _____

Any additional information you would like to include? _____

In Case of Emergency

Emergency Contact: _____ Phone: _____

Medical Doctor: _____ Phone: _____

Health History

Are you currently taking any medications? Yes No If yes, please list medications and dosages:

If you have had any of the following conditions, please circle:

- | | | | |
|--------------------|----------------|---------------------|------------------|
| Heart Attack | Stroke | Cong. Heart Defect | Alcohol Abuse |
| HIV+ | Neck Pain | High Blood Pressure | Drug Abuse |
| AIDS | Headaches | Low Blood Pressure | Shingles |
| Fainting | Seizures | Epilepsy | Diabetes Type I |
| Low Back Pain | Emphysema | Glaucoma | Diabetes Type II |
| Psychiatric Issues | Sinus Problems | Artificial Valves | Cancer |
| Anemia | Ulcers | Asthma | Arthritis |

Please list any medical conditions or surgeries you have had with dates: _____

Known Allergies (list all) _____

Family Health History: _____

Do you take supplements or vitamins? Yes No If so, what? _____

What is your typical exercise routine? _____

Are you on a special diet? Yes No If so, what is it? _____

Do you smoke? Yes No How much? _____ How long? _____

For Women: Are you taking birth control? Yes No

Are you pregnant? Yes No How far along? _____ Nursing Yes No

I understand the above information and have accurately completed it to the best of my knowledge. It is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date: _____

Records Release

North Lakes Chiropractic is authorized to release any information deemed appropriate concerning my physical condition, including diagnosis and records of treatment or examination, to my insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.

Signature: _____ Date _____

Thank you for choosing North Lakes Chiropractic