The Holistic Center At Bristol Square
New Patient Intake Form

Personal History

Name_____ **Address**_____

City_____ **State:**_____ **Zip Code**_____

Home Phone:_____ **Birth Date:**_____ **Age:**___ **Sex: M or F**

Circle One: Married Single Widowed Divorced Separated

Social Security # _____ **Business Employer:**_____

Business Phone:_____ **Type of Work:**_____

Name of Spouse:_____ **Spouse's Employer:**_____

Spouse's Work Phone:_____ **Type of Work:**_____

Names and Ages of Children:_____

Referred to this office by:_____

Name and Number of Emergency Contact:_____

Relationship:_____

Who is Responsible For Your Bill: You ( ) Spouse ( ) Worker's Comp ( )
Auto Insurance ( ) Medicare ( ) Medicaid ( )

Personal Health Insurance (Name):_____

Personal Health Insurance Number:_____

Cell Phone:_____ **Email:**_____

Current Health Condition

Purpose of this Appointment:_____

Other Doctors Seen For This Condition: ( ) Yes No ( ) Who:_____

Type of Treatment:_____ **Results:**_____

When Did This Condition Begin:_____ Has It Occurred Before:Yes ( ) No( )

Is Condition: ( )Job Related ( )Auto Accident ( )Home Injury ( )Fall ( )Other_____

Date of Accident:_____ Time Of Accident:_____

Have You Made A Report of Your Accident To Your Employer: ( )Yes ( ) No

Drugs You Now Take: ( )Nerve Pills ( )Pain Killers/Muscle Relaxers
( )Blood Pressure Medicine ( )Insulin ( ) Other_____

Do You Wear A Shoe Lift: ( ) Yes ( ) No

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us:_____

Past Health History

Please Check and Describe:

Major Surgery/Operations: ( )Appendectomy ( )Tonsillectomy ( )Gall Bladder
( )Hernia ( )Back Surgery ( )Broken Bones ( )Other_____

Major Accident or Falls:_____

Hospitalization (Other Than Above):_____

Previous Chiropractic Care: ( )None ( )Doctor's Name & Approximate Date of Last Visit:_____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

Check any of the following diseases you have had:

( )Pneumonia	**( )Mumps**	**( )Influenza**	**Intake**
( )Rheumatic Fever	**( )Small Pox**	**( )Pleurisy**	**( )Coffee**
( )Polio	**( )Chicken Pox**	**( )Arthritis**	**( )Tea**
( )Tuberculosis	**( )Diabetes**	**( )Epilepsy**	**( )Alcohol**
( )Whooping Cough	**( )Cancer**	**( )Mental Disorders**	**( )Cigarettes**
( )Anemia	**( )Heart Disease**	**( )Lumbago**	**( )White Sugar**
( )Measles	**( )Thyroid**	**( )Eczema**	

Have you been tested HIV positive: ( )Yes ( )No

Check any of the following you have had in the past 6 months:

Musculo-Skeletal Code
( )Low Back Pain
( )Pain Between Shoulders
( )Neck Pain
( )Arm Pain
( )Joint Pain/Stiffness
( )Walking Problems
( )Difficult Chewing/Clicking Jaw
( )General Stiffness

( )Gas/Bloating After Meals
( )Heartburn
( )Black/Bloody Stool
( )Colitis

Females Only:
Date of last Period:___

Are you Pregnant:___

Genito-Urinary Code
( )Bladder Trouble
( )Discolored Urine

Nervous System Code
( )Nervous
( )Numbness
( )Paralysis
( )Dizziness
( )Forgetfulness
( )Confusion/Depression
( )Fainting
( )Convulsions
( )Cold/Tingling Extremities

( ) C-V-R Code
( )Chest Pain
( )Short Breath
( )Blood Pressure Problems
( )Irregular Heartbeat
( )Heart Problems
( )Lung Problems/Congestion
( )Varicose Veins
( )Ankle Swelling
( )Stroke

General Code
( )Fatigue
( )Allergies
( )Loss of Sleep
( )Fever
( )Headaches

EENT Code
( )Vision Problems
( )Dental Problems
( )Sore Throat
( )Earaches
( )Hearing Difficulty
( )Stuffed Nose

Gastro-Intestinal Code
( )Poor/Excessive Appetite
( )Excessive Thirst
( )Frequent Nausea
( )Vomiting
( )Diarrhea
( )Constipation
( )Hemorrhoids
( )Liver Problems
( )Gall Bladder Problems
( )Weight Trouble

Male/Female Code
( )Menstrual Irregularity
( )Menstrual Cramps
( )Vaginal Pain/Infection
( )Breast Pain/Lumps
( )Prostate/Sexual Dysfunction
( )Other Problems
( )_____

( )Abdominal Cramps

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

( )Relief Care	**( )Corrective Care**	**( )Check here if you want the Doctor to select the type of care appropriate for Your condition.**

_____ _____

Date Patients Signature

If this is an accident related injury, please fill out the Accident Form. Thank You!

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand That the Doctor's office will prepare any necessary reports and forms to assist me in making collection from insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate throughout my spine. It is understood and agreed the amount paid the Doctor is for examination and x-rays only. The x-ray negatives will remain the property of this office being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient's Signature:_____ Date:_____

Guardian or Spouse's
Signature of Authorizing Care_____ Date:_____