Winnebago Chiropractic

New Patient Information

PATIENT INFORMATION

First Name: _____ M.I.:_____
Last Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Sex: ☐M ☐F Age: _____ Birthdate: ____/____/_____
SS#: _____-____-_____ Number of Children: _____
Home Phone: (_____)- _____-_____
Cell Phone: (_____)-_____-_____
Email: _____

SPOUSE OR RELATIVE INFORMATION

Marital Status: ☐Married ☐ Single ☐Separated
☐ Widowed ☐ Divorced ☐Minor
Spouse First Name: _____
Spouse Last Name: _____
Spouse Employer: _____
Employment Status: __F/T __P/T __Self Employed
__Retired __Not Employed __Student
Spouse Work Phone: (_____)- _____-_____
Spouse Cell Phone: (_____)- _____-_____

EMPLOYMENT STATUS

Employer: _____
Job: _____
Employer Address: _____
Employer City: _____State: _____Zip: _____
Employer Phone: (_____)-_____-_____
Employment Status: __F/T __P/T __Self Employed
__Retired __Not Employed __Student

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____
Emergency Contact Phone: (_____) _____-_____
Relationship to Patient: _____

OTHER INFORMATION

Have you been to a chiropractor before? ☐Yes ☐No
How did you hear about us? _____
Females: Are you pregnant? Yes No Unsure
Due Date: ____/____/_____

PRIMARY INSURANCE INFORMATION

Insurance Company: _____
Subscriber: _____
Relationship to Patient: _____
Policy Number: _____
Group Number: _____
Person Responsible for Payment: _____
Deductible: _____ Amount Met This Year: _____
Co-pay: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____
Subscriber: _____
Relationship to Patient: _____
Policy Number: _____
Group Number: _____
Person Responsible for Payment: _____
Deductible: _____Amount Met This Year: _____
Co-pay: _____

*If the patient will be using insurance benefits, please sign and date the form below.

INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____and assign directly to Winnebago Chiropractic, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor(s) to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

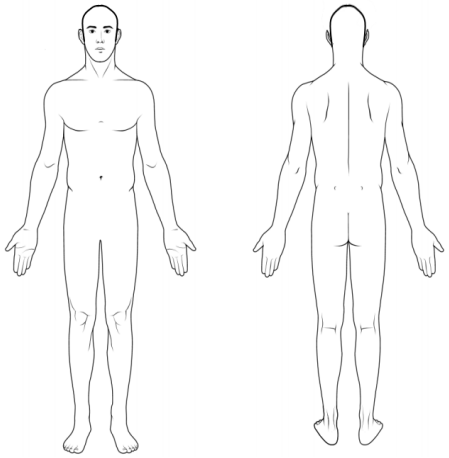
_____ _____
Responsible Party Signature Date

I request that payment of authorized Medicare benefits be made of my behalf to Winnebago Chiropractic, LLC for any services furnished to me. I authorize any holder of medical information about me to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____
Responsible Party Signature Date

PATIENT CONDITION

Reason for Visit: _____
When did your symptoms start? _____
Rate the severity of pain from 1 (least pain) to 10 (severe pain)_____
Mark an **"X"** on the picture where you notice the discomfort.
Type of Pain (circle): Dull Aching Sharp Throbbing Shooting Numbness Weakness Tingling Cramps Stiffness Soreness Other
Does the pain radiate into the arms and/or legs? _____
How often is the discomfort? Occasional Intermittent Frequent Constant
What aggravates the pain? _____
What alleviates the pain? _____
Is there a time of day that is better for the pain? Worse? _____



HEALTH HISTORY

What treatment have you already received for your condition (circle)? Medications Surgery PT Chiropractic None Other
Please list Primary Care Physician and Phone Number: _____
Have you had any previous imaging? ___ X-Rays ___ MRI ___Bone Density Other _____
Please list date of last: Physical Exam: ____/____/_____ Spinal Exam: ____/____/_____ Spinal X-Ray: ____/____/_____
MRI: ____/____/_____ CT-scan: ____/____/_____ Bone Scan: ____/____/_____

PLEASE LIST ALL ACCIDENTS, INJURIES, FRACTURES, HOSPITALIZATIONS & SURGERIES. IF NONE PLEASE WRITE: *NONE*

Accidents, Injuries, Fractures (Dates): _____
_____
_____
Hospitalizations, Surgeries (Dates): _____
_____

MEDICATIONS USED

_____
_____
_____
_____
_____

ALLERGIES

Medication:_____
_____
Environment:_____
_____
Food:_____

VITAMINS/HERBS/MINERALS

_____
_____
_____
_____
_____

REVIEW OF SYSTEMS. PLEASE CHECK "YES" OR "NO"

Anemia	__Yes __No	Eating Disorder	__Yes __No	Liver Disease	__Yes __No	Psychiatric Care	__Yes __No
Appendicitis	__Yes __No	Emphysema	__Yes __No	Lou Gehrig's	__Yes __No	Rheumatoid Arthritis	__Yes __No
Arthritis	__Yes __No	Epilepsy	__Yes __No	Measles/Mumps	__Yes __No		
Asthma	__Yes __No	Glaucoma	__Yes __No	Migraines	__Yes __No	STDs	__Yes __No
Blood Disorder	__Yes __No	Heart Disease	__Yes __No	Mononucleosis	__Yes __No	Stroke	__Yes __No
Breast Lump	__Yes __No	Hernia	__Yes __No	Multiple Sclerosis	__Yes __No	Tonsillitis	__Yes __No
Bronchitis	__Yes __No	Herniated Disc	__Yes __No	Osteoporosis	__Yes __No	Tuberculosis	__Yes __No
Cancer	__Yes __No	High Blood Pressure	__Yes __No	Pacemaker	__Yes __No	Tumors/ Growths	__Yes __No
Cataracts	__Yes __No			Parkinson's	__Yes __No		
Chemical Dependency	__Yes __No	High Cholesterol	__Yes __No	Pneumonia	__Yes __No	Ulcers	__Yes __No
		Hyperthyroid	__Yes __No	Polio	__Yes __No	Whooping Cough	__Yes __No
Chicken Pox	__Yes __No	Hypothyroid	__Yes __No	Prostate Problems	__Yes __No		
Diabetes	__Yes __No	Kidney Disease	__Yes __No			Other _____	

FAMILY HISTORY. MARK "P" FOR PARENT OR "S" FOR SIBLING

Alzheimer's	__P __S	Heart Problems	__P __S
Arthritis	__P __S	Hypertension	__P __S
Cholesterol	__P __S	Osteoporosis	__P __S
Cancer	__P __S	Psychiatric	__P __S
Diabetes	__P __S	Stroke	__P __S
Epilepsy	__P __S	Thyroid Disorder	__P __S

SOCIAL HISTORY. PLEASE CHECK WHAT APPLIES

Caffeine/Coffee Use	__Often __Occasionally __Never
Drink Alcohol	__Often __Occasionally __Never
Exercise	__Daily __Weekly __Never
Smoke/Chew Tobacco	__Daily __Occasionally __Never
	__Former _____How long quit?
Exercise	__Often __Occasionally __Never