WELLSPRING HEALTH GROUP

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NEW PATIENT INFORMATION

Date: ___/___/___

First Name _____ **Nick Name** _____

Last Name _____ **Middle Name** _____ **Suffix** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone _____ **Mobile Phone** _____

Email _____

Contact Method (Choose One)

☐ Home Phone ☐ Mobile Phone ☐ Work Phone

Date of Birth ___/___/___ **Age** _____ **Gender** ☐ Male ☐ Female

Marital Status ☐ Single ☐ Married ☐ Other **Number of Children** _____

Have you ever been treated by a chiropractor before? ☐ Yes ☐ No

If so, whom? _____ If so, when? ___/___/___

Employment Status (Choose One)

☐ Employed ☐ FT Student ☐ Other ☐ Retired ☐ Self Employed

Employer _____ **Work Phone** _____

Emergency Contact _____ **Phone** _____

Is this injury or illness work-related? ☐ Yes ☐ No

If so, have you reported it to your employer? ☐ Yes ☐ No

Is this injury or illness related to an automobile accident? ☐ Yes ☐ No

Insurance Company _____ **Name of Insured** _____

☐ Medicare ☐ Worker's Comp. ☐ Self-Pay

Have you ever been in an auto accident? Describe. _____

_____

Do you currently smoke tobacco of any kind? ☐Yes ☐Former Smoker ☐Never smoked

List any surgeries and dates

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Current medications, including dosage.

☐I am not currently taking any medications

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List any known reactions you have had to any medications and allergies.

☐No known reactions to medications or allergies

_____

Please list any Vitamins and Supplements _____

_____

REASON FOR VISIT

On a scale from 1-10, please describe the pain and its location _____

_____

When did the condition begin? ___/___/___

Is this condition getting worse? ☐Yes ☐No ☐Constant ☐Comes and Goes

Have you had this or similar conditions in the past? ☐Yes ☐No

If so, please explain _____

Have you been treated for this problem? ☐Yes ☐No

If so, whom? _____ If so, when? ___/___/___

Have you had any of the following studies? Please Date.

☐Spinal X-Ray ___/___/___ ☐MRI/CT ___/___/___ ☐Chest X-Ray ___/___/___

☐Bone Scan ___/___/___ ☐Urine Test ___/___/___

Do you currently wear the following? ☐Heel Lift ☐Orthotics

Does anyone in your family have a history of the following? Please list who.

☐ Heart Disease _____ ☐ Diabetes _____

☐ Kidney Disease _____ ☐ Cancer _____

☐ Stroke/TIA _____ ☐ Autoimmune Disease _____

Do you have a history of any of the following?

☐ Allergies	☐ Asthma	☐ Arthritis
☐ Bleeding Disorders	☐ Diabetes	☐ Cancer
☐ Fracture/Broken Bones	☐ Dizziness	☐ Gout
☐ Hepatitis	☐ Headache/Migraines	☐ High Blood Pressure/Heart Disease
☐ Kidney Disease	☐ Liver Disease	☐ Autoimmune Disease
☐ Osteoporosis	☐ Rheumatoid Arthritis	☐ Thyroid Disease
☐ TMJ	☐ Varicose Veins	☐ Stroke/TIA

WOMEN: Last monthly period ____/____/____ Are you pregnant? ☐ Yes ☐ No

Check symptoms you currently have or have had in the past year.

NECK	MID-BACK	LOW BACK
☐ Pain	☐ Pain	☐ Pain
☐ Stiffness	☐ Stiffness	☐ Stiffness
☐ Weakness	☐ Weakness	☐ Weakness
☐ Muscle Spasm	☐ Muscle Spasm	☐ Muscle Spasm
☐ Arm Pain/Numbness	☐ Rib Pain	☐ Leg Pain/Numbness

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any services rendered.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ **Date** ____/____/____

☐ Adult Patient ☐ Parent or Guardian ☐ Spouse