MANLEY & OBBINK CHIROPRACTIC AND ACUPUNCTURE

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New Patient Information

Date: ___ / ___ / ___

Name: _____ Middle Initial _____ Birthdate: ___ / ___ / ___ Age: _____

Nickname _____ No. of Children ____ SSN: _____ □ Married □ Single □ Divorced □ Widowed

Street Address: _____ □ Male □ Female

City: _____ State: _____ Zip: _____

Telephone: Home: _____ Work: _____ Cell: _____

Email Address: _____ Occupation: _____

Employer: _____ Phone: _____

Spouse's Name: _____ Spouse's Employer: _____

Emergency contact: _____ Relation: _____ Phone: _____

Whom may we thank for referring you to our office? _____

If not referred, how did you choose us? (yellow pages, internet, radio, television, insurance, etc.) _____

Reason for Visit

Please explain the pain & its location: _____

_____

Explain what happened: _____

When did your condition begin? _____ / _____ / _____ Is this condition getting worse? □ Yes □ No

Have you had similar conditions in the past? □ Yes □ No If yes, explain: _____

_____

Have you been treated by a Medical Physician for this condition: □ Yes □ No Whom? _____

Have you ever been treated by a Chiropractor before? □ Yes □ No Whom? _____

Health History

Do you have or have you ever had any of the following diseases or conditions?

Y N Heart Attack/Stroke
Y N Congenital Heart Defect
Y N Alcohol/Drug Abuse
Y N HIV+/AIDS
Y N Frequent Neck Pain
Y N High/Low Blood Pressure
Y N Severe/Frequent Headaches
Y N Fainting/Seizures/Epilepsy
Y N Diabetes/Tuberculosis
Y N Lower Back Problems
Y N Heart Surgery/Pacemaker
Y N Mitral Valve Prolapse
Y N Venereal Disease
Y N Shingles
Y N Emphysema/Glaucoma
Y N Psychiatric Problems
Y N Kidney Problems
Y N Sinus Problems
Y N Difficulty Breathing
Y N Artificial Bones/Joints
Y N Heart Murmur
Y N Artificial Valves
Y N Hepatitis
Y N Cancer
Y N Anemia
Y N Rheumatic Fever
Y N Ulcers/Colitis
Y N Asthma
Y N Irritable Bowel Syn.
Y N Arthritis

Please list any other serious medical condition(s) you have or ever had:

_____

Please list anything you may be allergic to: _____

List previous surgeries/treatments & dates: _____

List any past serious accidents & dates: _____

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

Are you currently taking: □ Pain Killers □ Muscle Relaxers □ Ibuprofen/Aspirin □ Other _____

Please list any <u>medications</u> or <u>supplements</u> that you are taking for your health. What are they for?

_____
_____
_____
_____
_____
_____

Does anyone in your family have any history of the following diseases/conditions? If so, whom?

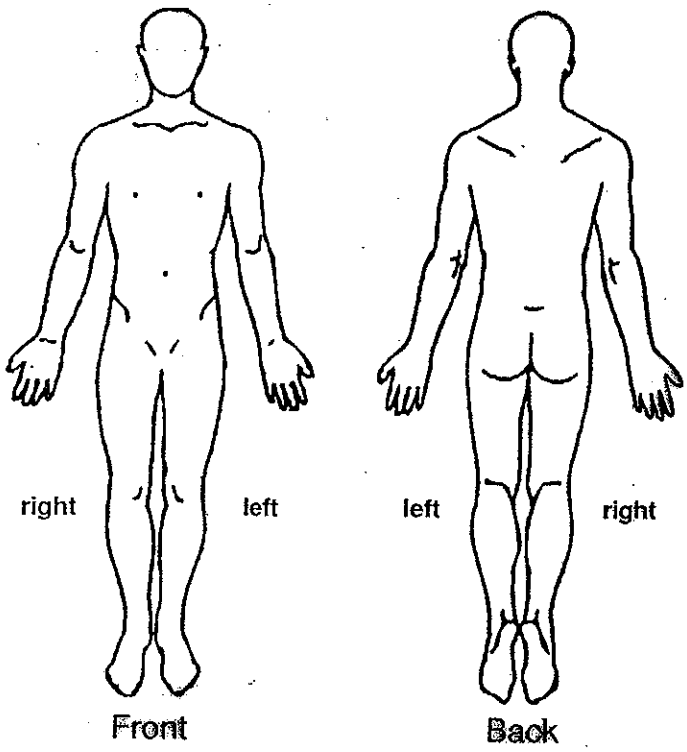
Y N Heart Disease _____
Y N Diabetes _____
Y N MS/Alzheimer's _____
Y N Asthma/Allergies _____
Y N Thyroid Problems _____
Y N Lactose Intolerance _____
Y N Cancer_____
Y N Rheumatoid Arthritis_____
Y N Parkinson's _____
Y N Eczema/Psoriasis _____
Y N Autoimmune Diseases _____
Y N Wheat Intolerance _____
Other (please list) _____

For Women: Are you taking Birth Control? □ Yes □ No If so, what type? (pill, IUD, etc) _____
Are you pregnant? □ No □Yes/How long?_____ Currently Nursing? □ Yes □ No

Pain Chart

Please indicate areas of pain or discomfort using the appropriate symbols from the chart below:

Numbness	Pins & Needles	Burning	Aching	Stabbing
NNNN	PPPP	BBBB	AAAA	SSSS



Doctor's Notes

- 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 that I have provided.

- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize Manley & Obbink Chiropractic and Acupuncture to release any information required to process insurance claims. I agree to be financially responsible for any services submitted to my insurance company if they are deemed to be a non-covered benefit, not medically necessary, or if my insurance benefits have been maxed out.

- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. Any unpaid balance over 90 days of the date of service will be charged 12% interest.

Signature _____ Date _____/_____/_____

□Adult Patient □Parent or Guardian □Spouse