**NEW PATIENT FORM**

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| **PATIENT INFORMATION** |  | **INSURANCE** |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | State: \_\_\_\_ | Who is responsible for this account? \_\_\_\_\_\_\_\_\_\_\_\_ |
| Zip Code: \_\_\_\_\_\_\_ |  | Is patient covered by additional insurance? 🞏 Y 🞏 N  |
| Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Subscriber’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Sex: 🞏 M 🞏 F | Age: \_\_\_ Birthday: \_\_\_\_\_\_\_\_\_ | Birthday: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | SSN: \_\_\_\_\_\_\_\_\_\_\_\_ |
| SSN/Patient ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Status:  | Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Employer/School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **ASSIGNMENT AND RELEASE**I certify that I, and/or my dependent(s), have insurance coverage with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_and assign directly to Dr. Danielle Rothman, D.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_Signature of Patient, Parent, Guardian, or Personal Representative Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_Print Name of Patient, Parent, Guardian, or Personal Representative Date |
| Employer/School Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer/School Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birthday: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **PHONE NUMBERS** |  | **ACCIDENT INFORMATION** |
| Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Is condition due to accident? 🞏 YES 🞏 NO |
| **IN CASE OF EMERGENCY, CONTACT:** |  | Type of accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | To whom have you made a report of the accident? |
| Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Attorney Name (if applicable): |

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| **PATIENT CONDITION** |
| Reason for visit: | Mark an X on the picture where you continue to have pain, numbness, or tingling |
| When did your symptoms appear? |
| Is this condition getting progressively worse? 🞏 YES 🞏 NO 🞏UNKNOWN |
| Rate the severity of your pain on a scale from 1 (least) to 10 (severe): |
| Type of pain:

|  |  |  |  |
| --- | --- | --- | --- |
| 🞏 Sharp | 🞏 Dull | 🞏 Throbbing | 🞏 Numbness |
| 🞏 Burning | 🞏 Tingling | 🞏 Cramps | 🞏 Stiffness |
| 🞏 Aching | 🞏 Swelling | 🞏 Shooting | 🞏 Other: |

 |
| How often do you have this pain?  |
| Is it constant or does it come and go? |
| Does it interfere with your:

|  |  |  |  |
| --- | --- | --- | --- |
| 🞏 Work | 🞏 Sleep | 🞏 Daily Routine | 🞏 Recreation |

 |
| Activities or movements that are painful to perform:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 🞏 Sitting | 🞏 Standing | 🞏 Walking | 🞏 Bending | 🞏 Lying Down |

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| **HEALTH HISTORY** |
| What treatment have you already received for your condition?

|  |  |
| --- | --- |
| 🞏 Medications | 🞏 Surgery |
| 🞏 Physical Therapy | 🞏 Chiropractic Services |
| 🞏 None | 🞏 Other:  |

Date of last:

|  |  |  |
| --- | --- | --- |
| Physical Exam: | Spinal X-Ray: | Blood Test: |
| Spinal Exam: | Chest X-Ray: | Urine Test: |
| Dental X-Ray: | MRI/CT Scan/Bone Scan: |  |

Are you pregnant? 🞏 YES 🞏 NO Due Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CONTINUED ON NEXT PAGE 🡪 |

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| **HEALTH HISTORY (CONTINUED)** |
| Place a mark on “YES” or “NO” if to indicate if you have had any of the following:

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| AIDS/HIV | 🞏 YES | 🞏 NO | Diabetes | 🞏 YES | 🞏 NO | Liver Disease | 🞏 YES | 🞏 NO | Rheumatic Fever | 🞏 YES | 🞏 NO |
| Alcoholism | 🞏 YES | 🞏 NO | Emphysema | 🞏 YES | 🞏 NO | Measles | 🞏 YES | 🞏 NO | Scarlet fever | 🞏 YES | 🞏 NO |
| Allergy Shots | 🞏 YES | 🞏 NO | Epilepsy | 🞏 YES | 🞏 NO | Migraines | 🞏 YES | 🞏 NO | Stroke | 🞏 YES | 🞏 NO |
| Anemia | 🞏 YES | 🞏 NO | Fractures | 🞏 YES | 🞏 NO | Miscarriage | 🞏 YES | 🞏 NO | Suicide Attempt | 🞏 YES | 🞏 NO |
| Anorexia | 🞏 YES | 🞏 NO | Glaucoma | 🞏 YES | 🞏 NO | Mononucleosis | 🞏 YES | 🞏 NO | Thyroid Problems | 🞏 YES | 🞏 NO |
| Appendicitis | 🞏 YES | 🞏 NO | Goiter | 🞏 YES | 🞏 NO | Multiple Sclerosis | 🞏 YES | 🞏 NO | Tonsillitis | 🞏 YES | 🞏 NO |
| Arthritis | 🞏 YES | 🞏 NO | Gonorrhea | 🞏 YES | 🞏 NO | Mumps | 🞏 YES | 🞏 NO | Tuberculosis | 🞏 YES | 🞏 NO |
| Asthma | 🞏 YES | 🞏 NO | Gout | 🞏 YES | 🞏 NO | Osteoporosis | 🞏 YES | 🞏 NO | Tumors, Growths | 🞏 YES | 🞏 NO |
| Chicken Pox | 🞏 YES | 🞏 NO | Heart Disease | 🞏 YES | 🞏 NO | Pacemaker | 🞏 YES | 🞏 NO | Typhoid Fever | 🞏 YES | 🞏 NO |
| Breast Lump | 🞏 YES | 🞏 NO | Hepatitis  | 🞏 YES | 🞏 NO | Parkinson’s Disease | 🞏 YES | 🞏 NO | Ulcers | 🞏 YES | 🞏 NO |
| Bronchitis | 🞏 YES | 🞏 NO | Hernia | 🞏 YES | 🞏 NO | Pinched Nerve | 🞏 YES | 🞏 NO | Vaginal Infections | 🞏 YES | 🞏 NO |
| Bulimia | 🞏 YES | 🞏 NO | Herniated Disk | 🞏 YES | 🞏 NO | Pneumonia | 🞏 YES | 🞏 NO | Whopping Cough | 🞏 YES | 🞏 NO |
| Cancer | 🞏 YES | 🞏 NO | Herpes | 🞏 YES | 🞏 NO | Polio | 🞏 YES | 🞏 NO | Sexually Transmitted Infection | 🞏 YES | 🞏 NO |
| Cataracts | 🞏 YES | 🞏 NO | High Cholesterol | 🞏 YES | 🞏 NO | Prostate Problem | 🞏 YES | 🞏 NO |
| Chemical Dependency | 🞏 YES | 🞏 NO | High Blood Pressure | 🞏 YES | 🞏 NO | Prosthesis | 🞏 YES | 🞏 NO | Bleeding Disorders | 🞏 YES | 🞏 NO |
|  |  |  | Kidney Disease  | 🞏 YES | 🞏 NO | Psychiatric Care | 🞏 YES | 🞏 NO |

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **EXERCISE**🞏 None🞏 Moderate🞏 Daily🞏 Heavy | **WORK ACTIVITY**🞏 Sitting🞏 Standing🞏 Light Labor🞏 Heavy Labor | **HABITS**🞏 Smoking: Packs/Day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_🞏 Alcohol: Drinks/Week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_🞏 Coffee/ Caffeine Drinks: Cups/Day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_🞏 High Stress Level: Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **INJURIES/SURGERIES**Please describe below. Include appropriate dates. |
| **MEDICATIONS**Please list any medications you take: | **ALLERGIES**Please list any allergies you have: | **VITAMINS/HERBS/MINERALS**Please list any vitamins/herbs/minerals you are taking: |