New Patient Health History Form

In order to provide you the best possible care, please complete this form and bring it to yur first appointment.

Patient Data

First Name:_____________________ Last Name:_______________________ Date:_________
E-mail:_____________________________ Preferred Phone Number:_________________

Mailing Address

Address:_____________________________ City:___________________ State:_________ Zip:_______
Age:_____ Birthdate:____________ Social Security #________________ # of children: _______
Referred By:______________ Occupation________________ Employer_________________
Marital Status_____________ Spouse's Name________________ Spouse's Health Status___________
Emergency Contact:__________________________ Phone Number____________________________

Current Complaints

Nature of injury: Automobile____Work____Other____
Please describe:

Date of injury:_____________ Date symptoms appeared:________________
Have you ever had the same condition? No___ Yes___ If yes, when?____________
List of other practitioners seen for this injury/ conditon________________________
Have you ever been under chiropractic care? No___ Yes___
If yes, please describe____

Insurance Information

Name of party responsible for payment_________________________Phone___________________
Do you have health insurance? No___ Yes___ Name of company___________________________

Signatures

Name of the insured____

I understand and agree that health/accident policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature____ Date________________
Spouse's or guardian's signature_______________________________ Date________________

Medical History
Have you been treated for any conditions in the last year? No___ Yes___ If yes, please describe____ Date of last physical exam______________ If there is a chance that you are pregnant? No___ Yes___ Have you had X-rays taken? No___ Yes___ If yes, where?______________________ What medications are you taking and for what conditions What vitamins, minerals, or herbs do you currently take? Height______Weight______Allergies(Specify):__________________________________

Have you ever:	No	Yes	Briefly Explain
Broken bones?			
Been hospitalized?			
Been in an auto accident?			
Had Sprains/Strains?			
Been struck unconscious?			
Had surgery?			

Family History
Family Members-Present and Past history conditions (Heart disease,cancer,diabtes,etc.

Habits	None	Light	Moderate	Heavy
Alcohol				
Tobacco				
Exercise				
Water				
Sleep				
Coffee				
Soft Drinks				

Instructions: Please circle the correct response.

I. HISTORICAL INFORMATION

Have you ever been diagnosed or told you had any of the following?

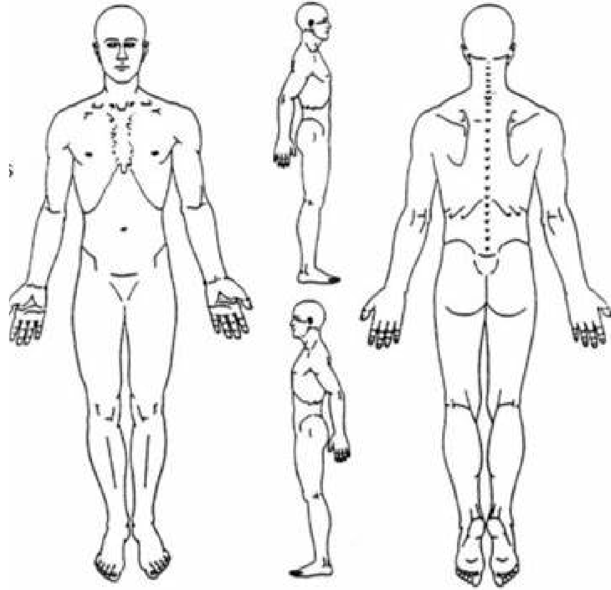
1. High blood pressure (Hypertension).............Yes No
2. Hardening of the arteries (Arteriosclerosis)..Yes No
3. Diabetes……………………………………..Yes No
4. Heart or blood vessel disease……...………Yes No
5. Bone spurs on the neck bones (cervical spondylosis/osteoarthritis/degenerative joint disease)...Yes No
6. Whiplash injury (flexion-extension injury (cervical sprain)...Yes No
7. Have any of your relatives suffered a stroke?Yes No
8. Were you ever a smoker? From________ to________………………Yes No
9. Do you take any meds on a regular basis? Yes No What?(Coumadin, Heparin, Aspirion, etc.)______________________________________ ______________________________________
10. (Women only) Have you ever taken oral contraceptives? From_____ to______

Have you ever experienced any of the following, even short, temporary attacks?

11. Blurred vision………………………… Yes No
12. Double vision……………………… Yes No
13. Diminished or partial-loss in vision in one or both eyes?.. Yes No
14. Complete loss of vision in one or both eyes? Yes No
15. Ringing, buzzing or any noise in the ear(s)? Yes No
16. Hearing loss in one or both ears?............... Yes No
17. Slurred speech or other speech problems? Yes No
18. Difficulty swallowing?.................................. Yes No
19. DIzziness?... Yes No
20. Temporary lack of understanding?............ Yes No
21. Loss of consciousness, even momentary Blackouts?..Yes No
22. Numbness or loss of sensation in the face fingers, hands, arms, legs or other parts of your body?... Yes No
23. Any other abnormal sensation in any part of your body?..Yes No
24. Weakness, clumsiness or loss of strength in The face, fingers, hands, arms or legs?…. Yes No
25. Sudden collapse without loss of consciousness?..Yes No

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencir

A=Ache **B=**Burning **N=**Numbing **P=**Pins&Needles **S=**Stab



Have you ever suffered from:

___Alcoholism
___Allergies
___Anemia
___Arteriosclerosis
___Arthritis
___Asthma
___Back Pain
___Breast Lump
___Bronchitis
___Bruise Easily
___Cancer
___Chest Pain
___Cold Extremitis
___Constipation
___Cramps
___Depression
___Diabtes
___Digestion Issues
___Dizziness
___Ears Ringing
___Excessive Menstration
___Eye Pain or Difficulties
___Fatigue
___Frequent Urination
___Headaches
___Hemorrhoids
___High Blood Pressure
___Hot Flashes
___Irregular Heart Beat
___Irregualr Cycle
__Kidney Stone/Infection
__ Loss of memory
__Loss of balance
___Loss of taste or smell
___Neck Pain or Stiffness
___ Nervousness/ Anxiety
___Nosebleeds
___Pacemaker
___Polio
___Poor Posture
___Prostate Troubles
___Sciatic
___Shortness of breath
___Sinus Infection
___Sleep Problems/ Insomn
___Spinal Curvature/Scolios
___Stroke
___Swelling of legs
___Swollen Joints
___Thyroid Conditions
___Tuberculosis
___Ulcers
___Varicose Veins
___Venereal Disease
___Other:__________

Gorsuch Chiropractic Office Policy

Our ultimate goal at Gorsuch Chiropractic Center is to provide you with the highest quality care available. In an effort to accomplish this, we need you involved in all aspects of your treatment.

Gorsuch Chiropractic Center will call your insurance company to get an estimate of chiropractic benefits, as courtesy to you. This is not a guarantee of payment from your insurance company. We would strongly advise you to verify benefits for your own information. Your benefits are a contract between <u>YOU AND YOUR INSURANCE COMPANY</u>. We will help you in any way we can regarding outstanding charges, but ultimately any unpaid balance will be your responsibility.

We would expect you to keep updated with the status of your claims, which include following up with your insurance company if there is any delay in payment.

<u>CASH PATIENTS</u>:

In order to be a "cash patient", you are required to pay for service up front at the time of service. At that time we will give you a 25% discount on services only, (not on supplies). Being a "cash patient" means you are recieving a discount from us for not utilizing our billing department. (No claims will be printed for submission to insurance companies).

______________________________________ ________________

Patient Signature **Date**