Welcome to Sanchez Chiropractic Center, P.C.

Website: www.sanchezchiroctr.com

New Patient Registration and History Form

In order for us to provide the best possible care, please complete this form to the best of your ability.
All information is strictly confidential.

Today's Date: _____ Name:_____
Email:_____
(Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements and promotions.)

Who do we need to thank for referring you?

☐Website ☐Yellow Pages ☐ Internet ☐Friend (Please state name)_____ ☐ Other _____

How would you like for us to contact you in the future: ☐ email ☐ text ☐ mail

Mailing address _____

City _____ State_____ ZIP_____

Telephone: (home)_____(cell)_____(work)_____

Age _____ Birth Date _____ Social Security #_____

Occupation_____ Employer _____

Marital Status: □Single □Married □Divorced □Widowed Number of children_____

Spouse's Name_____ Spouse's Birth Date: _____
Spouse's Occupation_____ Spouse's Employer_____
Spouse's Social Security # _____
Emergency Contact _____
Relationship_____Phone#_____

Insurance

Name of party responsible for payment_____ Phone #_____

Relationship to patient ☐Self ☐Spouse ☐Other _____ Insurance Company Name_____
Group#_____ Member's ID # _____
Is patient covered by <u>additional</u> insurance? □Yes □No (If "NO", please go directly to 'Assigned & Release' section.)

Additional Insurance name _____ Group #_____ Member's ID #_____

Assignment and Release

I, the undersigned, certify that I (or my dependent/spouse) have insurance coverage with _____ and assigned directly to <u>Dr. Sanchez</u> all insurance benefits, if any. I understand and agree that health/accident insurance 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/treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature of Party Responsible _____Date_____

Spouse's or guardian's signature _____ Date_____

Current Complaints

What <u>reason/pain</u> has brought you here today?_____

What caused this pain?_____

Nature of Injury: □ Automobile (If so, please provide attorney/lawfirm and phone# that has been retained. _____

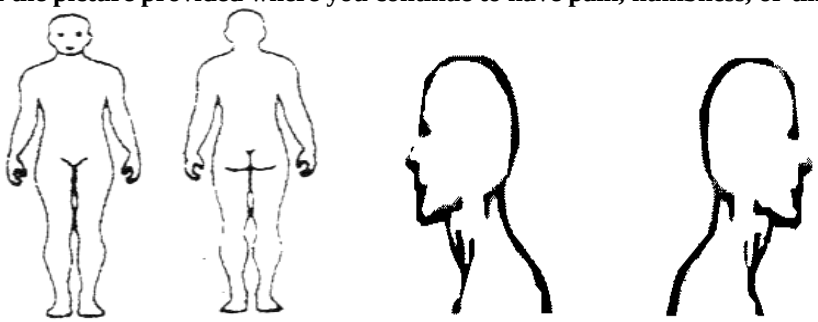
□ Work* (If so, please provide case worker, case#, and phone# of the worker's compensation.)_____

□Other _____

When did your symptoms appear?_____

Is this condition getting progressively worse? □Yes □No □Unknown

Mark an 'X' on the picture provided where you continue to have pain, numbness, or tingling.



Please rate below the severity of your pain on a scale from 1 (least pain) to 10 (severe pain).

○ **No Pain** ○ **Mild** ○**Moderate** ○**Severe** ○**Intolerable**

Type of pain:

□Sharp □Dull □Throbbing □Numbness □Aching □Shooting □Burning □Tingling

How often are you experiencing this pain?_____

Is it constant or does it come & go?_____

Does it interfere with your:

□ Work □ Sleep □ Daily Routine □Recreation □ Other □None of these?

Are any of these activities or movements painful to perform? (please mark X)

□Sitting □Standing □ Walking □ Bending □ Lying Down

What treatment have you already received for your condition?

□ Medications □ Surgery □ Physical Therapy □ Chiropractic Services □ None □ Other

Name and address of other doctor(s) who have treated you for this condition:

_____

_____

_____

Other Problem(s):

What are <u>other pain</u>(s) do you have?_____

_____

What caused this pain? _____

When did your symptoms appear?_____

Is this condition getting progressively worse? □Yes □No □Unknown

Please rate below the severity of your pain on a scale from 1 (least pain) to 10 (severe pain).

○ **No Pain** ○ **Mild** ○ **Moderate** ○ **Severe** ○ **Intolerable**

Other Problems cont…….

Type of pain:
□Sharp □Dull □Throbbing □Numbness □Aching □Shooting □Burning □Tingling
How often are you experiencing this pain?_____
Is it constant or does it come & go?_____
Does it interfere with your:
□ Work □ Sleep □ Daily Routine □Recreation □ Other □None of these?
Are any of these activities or movements painful to perform? (please mark X)
□Sitting □Standing □ Walking □ Bending □ Lying Down
What treatment have you already received for your condition?
□ Medications □ Surgery □ Physical Therapy □ Chiropractic Services □ None □ Other

Health History

Have you been treated for any other conditions in the last year? ☐ **Yes** ☐ **No**
Please describe_____
Is there a chance that you are pregnant? □**No** □ **Yes** **Due Date:** _____

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 :

Falls/Dislocations/ Broken Bones? □**No** □**Yes** **Briefly Explain**_____
Head Injuries? □**No** □**Yes** **Briefly Explain**_____
Had surgeries? □**No** □**Yes** **Briefly Explain**_____
Hospitalizations? □**No** □**Yes** **Briefly Explain**_____
_____
_____

Please list any medications you are currently taking: _____
_____
_____
_____

Please list any allergies: _____
_____

Please list any vitamins/herbs/minerals:
_____
_____
_____

Family History:
(Please list any SIGNIFICANT illnesses such as cancer, diabetes, heart disease or stroke.)

	Alive	Deceased	N/A	Present health/Cause of death
Father:	☐	☐		_____
Mother:	☐	☐		_____
Brothers	☐	☐	☐	_____
Sisters	☐	☐	☐	_____

Check illnesses which have occurred in any of your Blood Relatives: ☐ Diabetes ☐ Cancer ☐Stroke
If checked, please identify relationship (ex: aunt, uncle, and grandmother) _____

Place a mark in box "yes" or "no" to indicate if you <u>do</u> have or <u>ever had</u> any of the following:

Alcoholism	☐No ☐Yes	**Digestion Problems**	☐No ☐Yes	**Loss of taste & smell**	☐No ☐Yes
Allergies	☐No ☐Yes	**Menstruation problems**	☐No ☐Yes	**Migraine Headaches**	☐No ☐Ye
Eye pain or difficulties	☐No ☐Yes	**Miscarriage**	☐No ☐Yes	**Hot flashes**	☐No ☐Yes
Appendicitis	☐No ☐Yes	**Mononucleosis**	☐No ☐Yes	**Vaginal infection**	☐No ☐Yes
Arthritis	☐No ☐Yes	**Eating Disorder**	☐No ☐Yes	**Psychiatric Care**	☐No ☐Yes
Ears ring	☐No ☐Yes	**Multiple Arteriosclerosis**	☐No ☐Yes	**Emphysema**	☐No ☐Yes
Asthma	☐No ☐Yes	**Neck pain or stiffness**	☐No ☐Yes	**Urination problems**	☐No ☐Yes
Bleeding disorders	☐No ☐Yes	**Nervousness**	☐No ☐Yes	**Osteoporosis**	☐No ☐Yes
Gout	☐No ☐Yes	**Dizziness**	☐No ☐Yes	**Tumors/growths**	☐No ☐Yes
Bronchitis	☐No ☐Yes	**Suicide Attempt**	☐No ☐Yes	**Thyroid condition**	☐No ☐Yes
Cancer	☐No ☐Yes	**Swollen joints**	☐No ☐Yes	**Pneumonia**	☐No ☐Yes
Chemical Dependency	☐No ☐Yes	**Epilepsy**	☐No ☐Yes	**Sleep problems /insomnia**	☐No ☐Yes
Chicken Pox	☐No ☐Yes	**Hemorrhoids**	☐No ☐Yes	**Stroke**	☐No ☐Yes
Cold extremities	☐No ☐Yes	**Hernia**	☐No ☐Yes	**Sinus infection**	☐No ☐Yes
Constipation	☐No ☐Yes	**Herniated disk**	☐No ☐Yes	**Loss of memory**	☐No ☐Yes
Depression	☐No ☐Yes	**High blood pressure**	☐No ☐Yes	**Liver Disease**	☐No ☐Yes
Diabetes	☐No ☐Yes	**High Cholesterol**	☐No ☐Yes	**Shortness of breath**	☐No ☐Yes
Irregular heart beat	☐No ☐Yes	**Venereal disease**	☐No ☐Yes	**Kidney infection/stones**	☐No ☐Yes

Please state any further comments below that need to be noted and were not in the questionnaire.

_____

_____

_____

We would like to take the time now to say "welcome and thank you" for choosing Sanchez Chiropractic Center."