



Carolina Chiropractic & Wellness New Patient Form

Phone: 803-548-8452 Fax: 803-802-7732

8763 Charlotte Hwy Indian Land, SC 29707

Today's Date: ____/____/____ File# _____

Patient Name: _____

Last First MI

What You Prefer To Be Called: _____ Male Female

Birthdate: ____/____/____ Age: ____ SS#: _____

Mailing Address: _____

City _____ State _____ Zip _____

Home Phone #: _____

Work Phone#: _____ Ext: _____

Other Phone #: _____

E-mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

City State Zip

Occupation: _____

Status: Married Single Divorced Separated Widowed

Spouses Name: _____

Do you have any children? Yes No How Many? _____

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

City State Zip

SS#: _____

Drivers License #: _____

Work Phone #: (____) _____

Payment Method: Cash Check

_____/_____/_____
Credit Card- Enter card # above (if accepted)

_____(initials) I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Primary Insurance

Co. Name: _____

Address: _____

City _____ State _____ Zip _____

Phone #: _____

Insured's SS#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____

Date of Birth ____/____/____

Insured's Employer: _____

Secondary Insurance

Co. Name: _____

Address: _____

City _____ State _____ Zip _____

Phone #: _____

Insured's SS#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____

Date of Birth ____/____/____

Insured's Employer: _____

In Event of Emergency

Whom should we contact?

Relation: _____

Home Phone #: (____) _____

Work Phone #: (____) _____

Cell Phone #: (____) _____

Who is your Medical Doctor?

Medical Doctor's Phone #:

(____) _____



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Reason For Visit

Reason for today's visit: Emergency New Injury Old Injury Chronic pain Wellness

Are you in pain: Yes No Rate your pain with the following scale: discomfort _____ intense
1 2 3 4 5 6 7 8 9 10

Did your injury occur during: Work Sports/Play Auto Accident Routine/ Household Activity

When did your condition/accident occur? ____/____/____ Where did your injury occur? _____

Please explain what happened: _____

Is your condition getting worse? Yes No Constant Comes and goes.

Is your condition interfering with your: Work Sleep or Daily routine? If so, how: _____

Has this or something similar happened in the past? Yes No

Explain: _____

Using the adjacent body charts, please circle All affected areas.

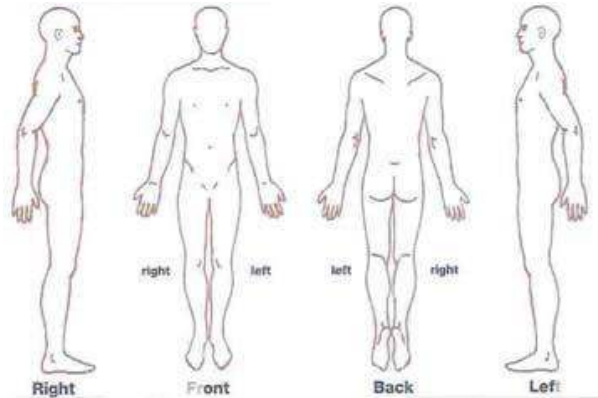
Have you been treated by a Medical Physician for this condition?

Yes No If so, where? _____

Have you ever been treated by a Chiropractor? Yes No

Clinic or Dr's name: _____

Clinic phone#: _____



Are you taking any of the following medications? Nerve Pills Pain Killers(including aspirin) Muscle relaxers

Blood Thinners Tranquilizers Insulin Other(s) _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

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

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: _____

List any past serious accidents with dates: _____

Please list anything that you may be allergic to: _____

Family Health History: _____

Do you take Supplements or Vitamins? Yes No Do you exercise? No Yes _____ hours per week

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

Are you wearing: Shoe lifts Inner soles Arch supports Are you dieting: No Yes Since: ____/____/____

For woman: Are you taking Birth Control? Yes No Are you Pregnant? No Yes If so, how many weeks? _____