NEW PATIENT REGISTRATION FORM

* Please note: If this will be involving a Worker's Compensation Claim or an Auto Accident, please see the Office Manager before filling out this form.

NAME (LAST, FIRST, MIDDLE INIT.)_____

ADDRESS (STREET)_____

(CITY, STATE, ZIP)_____

PHONE HOME:_____ CELL_____
Carrier:_____

DATE OF BIRTH(MM/DD/YY)_____

SOCIAL SECURITY NUMBER_____ EMAIL_____
(optional) (optional)

WOULD YOU LIKE TO RECEIVE EMAIL OR TEXT REMINDERS? YES __EMAIL __TEXT NO

WHOM MAY WE THANK FOR REFERRING YOU?_____

EMERGENCY CONTACT_____ PHONE _____

EMPLOYER (COMPANY NAME)_____ OCCUPATION_____

ADDRESS_____
(Street, City, State, Zip)
_____

PHONE NUMBER_____

INSURANCE COMPANY_____

SUBSCRIBER NAME_____ SUBSCRIBER ID _____
(policy holder's name)

GROUP NUMBER_____ RELATIONSHIP TO SUBSCRIBER_____
_____(self, spouse, child, other)

IS THERE AN HEALTH SAVINGS ACCOUNT? YES NO

IS THERE A HIGH DEDUCTIBLE? YES NO IF YES, THE AMOUNT_____

IS THERE A SECONDARY INSURANCE?_____
(List insurance company, ID #, group, etc.)

_____

REASON FOR YOUR VISIT TODAY_____

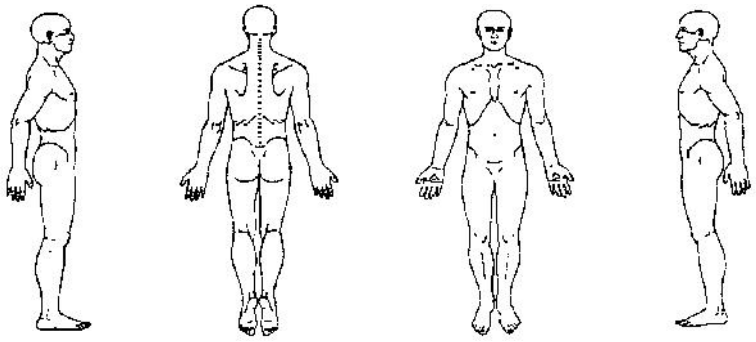
_____

WHEN DID YOUR SYMPTOMS FIRST APPEAR_____

(CONTINUED ON BACK)

IS THIS CONDITION GETTING PROGRESSIVELY WORSE? YES NO UNKNOWN

MARK AN "X" ON THE PICTURE WHERE YOU HAVE PAIN, NUMBNESS, TINGLING



WHAT IS THE SEVERITY OF YOUR PAIN? (Little or no pain, moderate, severe)_____

WHAT TYPE OF PAIN IS IT? (Sharp, burning, shooting, etc.)_____

IS THE PAIN INTERMITTENT OR CONSTANT?_____

DOES THE PAIN INTERFERE WITH WORK, SLEEP, DAILY ROUTINE _____

_____

HEALTH HISTORY

HAVE YOU RECEIVED TREATMENT FOR YOUR CURRENT CONDITION? YES NO

IF YES, PLEASE LIST_____

ARE YOU TAKING ANY MEDICATIONS OR SUPPLEMENTS? YES NO

IF YES, PLEASE LIST_____

PLEASE LIST ANY FALLS, INJURIES, OR SURGERIES YOU HAVE _____

_____

ARE YOU PREGNANT? YES NO DUE DATE_____

CIRCLE YOUR EXERCISE LEVEL: NONE MODERATE DAILY HEAVY

CIRCLE YOUR WORK ACTIVITY: SITTING STANDING LIGHT LABOR HEAVY LABOR

CIRCLE ANY HABITS YOU MAY HAVE: SMOKING ALCOHOL COFFEE/CAFFEINE HIGH STRESS

FREQUENCY:_____

PRIMARY CARE PHYSICIAN_____ PHONE_____

HAVE YOU HAD ANY X-RAYS, MRI'S, CT-SCANS, OR OTHER TESTING DONE? YES NO

IF YES, PLEASE EXPLAIN_____

_____

PLEASE LIST ANY ILLNESSES, DISEASES, CONDITIONS, OR CONCERNS YOU HAVE HAD:_____

_____