

WELCOME

SHAW CHIROPRACTIC CENTER

NEW PATIENT DATA SHEET

PATIENT NAME _____ Date _____
BIRTHDATE _____ AGE _____ SEX M/F SOCIAL SECURITY# _____ PHONE# _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
OCCUPATION: _____ EMPLOYER _____ WORK PHONE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
E-MAIL ADDRESS _____ MARITAL STATUS _____ # OF CHILDREN/ AGES _____

HOW DID YOU HEAR ABOUT US? _____

SUBSCRIBER NAME _____ HEALTH PLAN _____
SUBSCRIBER ID # _____ GROUP # _____ SPOUSE NAME _____
SPOUSE EMPLOYER _____ CITY _____ STATE _____ ZIP _____

1. DESCRIBE YOUR SYMPTOMS _____

2. WHEN DID THEY START _____

3. HOW DID THEY START _____

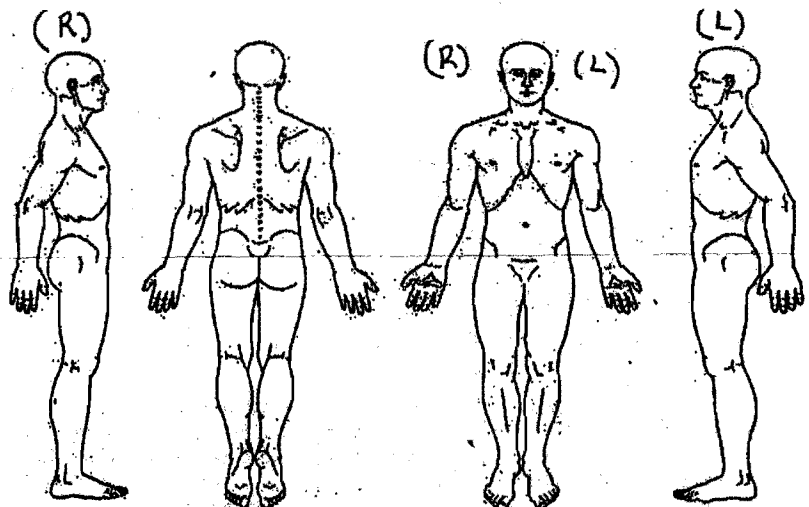
4. How often do you experience your symptoms?

- a. Constantly (76-100% of the day)
- b. Frequently (51-75% of the day)
- c. Occasionally (26-50% of the day)
- d. Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms

4. What describes the nature of your symptoms?

- a. Sharp
- b. Shooting
- c. Dull Ache
- c. Burning
- d. Numb
- e. Tingling



5. How are your symptoms changing?

- a. Getting Better
- b. Not Changing
- c. Getting Worse

6. During the past 4 weeks:

a. Indicate the average intensity of your symptoms: 0 _____ (none) _____ (unbearable) 10

b. How much has pain interfered with your normal work (including both outside the home and housework)
___ Not at all ___ A little Bit ___ Moderately ___ Quite a Bit ___ Extremely

7. During the past 4 weeks how much of the time has your condition interfered with your social activities?

All of the time Most of the time Some of the time A little of the time None of the time

8. In general would you say your overall health right now is...

Excellent Very Good Good Fair Poor

9. Who have you seen for your symptoms?

No one Medical Doctor Other Chiropractor Physical Therapist Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

X-rays date _____ MRI date _____ CT Scan date _____ Other date _____

10. Have you had similar symptoms in the past? Yes No

a. If you have received treatment in the past for the same or similar symptoms, whom did you see?

This Office Medical Doctor Other Chiropractor Physical Therapist Other

11. Is there a chance you are pregnant? Yes No

12. Do you wear a heel lift? Yes No

Please check all of the following that apply to you: None Apply

- | No | Yes | Condition |
|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | History of Recent Infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Corticosteroid Use |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Control Pills |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke (date) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness/Fainting |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness in Groin/Buttocks |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary Retention |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic Aneurysm |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer/Tumor |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Trauma |

- | No | Yes | Condition |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy, # of births _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight <input type="checkbox"/> Gain, <input type="checkbox"/> Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Low/Mid Back Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Neck Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Alcohol Use |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Tobacco Use |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgeries/Medications: _____ |
| | | _____ |
| | | _____ |
| | | _____ |

Family History: Cancer Diabetes High Blood Pressure Cardiovascular Problems/Stroke

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Shaw Chiropractic Center will ASSIST me in making collection from the insurance company and that any amount authorized to be paid directly to the Shaw Chiropractic Center will be credited to my account on receipt. However, I clearly understand and agree that I am personally responsible for payment of all present and future services rendered, including any charges my insurance company or Medicare denies or does not cover. Should Shaw Chiropractic Center elect to place my account in collections I shall become liable for all costs of collection including but not limited to collection agency or attorney fees as well as the total account balance due.

I understand that Shaw Chiropractic Center and its employees do not diagnose, treat, or claim to cure medical conditions and are not responsible for the diagnosis of any medical conditions. I understand that the practice of Chiropractic is based solely on the presence, analysis and correction of vertebral subluxations and other skeletal misalignments and I hereby authorize Dr. Shaw to provide Chiropractic Care for me.

Patient's Signature: _____ Date: _____

Legal Guardian's

Consent to Treat a Minor: _____ Date: _____