Kyles Chiropractic Clinic

Taking the pain out if life.

New Patient Form

Welcome to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your health.

Name (*Last*)_____ (*First*) _____ (*Initial*) _____ Soc. Sec. # _____

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ☐ M ☐ F Age _____ Birth Date _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed By _____ Occupation _____

Business Address _____

Business Phone _____ Business Email _____

Emergency Contact _____ Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Whom may we thank for referring you? _____

Primary Insurance

Person Responsible for the Account: Name (*Last*) _____ (*First*) _____ (*Initial*) _____

Relation to Patient _____ Birth Date _____ Soc. Sec. # _____

Address (*if different from patient*) _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Person Responsible Employed By _____ Occupation _____

Business Address _____

Business Phone _____ Business Email _____

Insurance Company _____

Phone _____ Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of Other Dependents Under this Plan _____

Reason for Visit

Have you ever seen a chiropractor? ☐ Yes ☐ No If yes, when and why? _____

Your reason for this visit? _____

Please describe your current pain and its location _____

When did symptoms begin (*date*) _____ Have you had similar conditions in the past? _____

Is pain getting: ☐ Worse ☐ Better ☐ Comes and goes How often do you have this pain? _____

Have you been treated by a medical physician for this condition? ☐ Yes ☐ No

If yes, when and where? _____

Activities or movements that are difficult/painful to perform: ☐ Sitting ☐ Walking ☐ Bending ☐ Lying Down ☐ Lifting

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Burning ☐ Tingling ☐ Numbness ☐ Cramping ☐ Stiffness ☐ Swelling ☐ Other _____

Is pain interfering with ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

PLEASE COMPLETE BOTH SIDES

 Patient Name _____

Health History

Please list any medication (including pain killers) you are taking _____

_____

Please list any serious injuries or surgeries you have had in the last 10 years:

	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Other Serious Injuries	_____	_____

WOMEN: Are you pregnant? ☐ Yes ☐ No If yes, how far along?_____ Nursing? ☐ Yes ☐ No

Medical Conditions

Have you ever had or do you currently have any of the following conditions?

☐ Heart Attack/Stroke	☐ Arthritis	☐ Ringing in Ears	☐ Ulcer/Colitis
☐ Congenital Heart Defect	☐ Frequent Neck Pain	☐ Severe/Frequent Headaches	☐ Gout
☐ Alcohol/Drug Abuse	☐ Jaw Pain	☐ Diabetes/Tuberculosis	☐ Numbness, where?_____
☐ Fainting/Seizures/Epilepsy	☐ Wrist Pain	☐ Dizziness	_____
☐ Shingles	☐ Shoulder Pain	☐ Emphysema/Glaucoma	☐ Tingling, where? _____
☐ Psychiatric Problems	☐ Arm Pain	☐ Kidney Problems	_____
☐ Difficulty Breathing	☐ Leg Pain	☐ Artificial Bones/Joints	☐ Muscle Spasms, where? _____
☐ Hepatitis	☐ Lower Back Problems	☐ Cancer	_____
☐ Anemia	☐ Sever/Frequent Earaches	☐ HIV Positive/AIDS	

Personal Habits

	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor.

I authorize my insurance company to pay the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or paid by insurance.

Signature _____ Date _____

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

Print Form Print a copy of this form or to bring to your appointment and/or for your records.

Email Form Click to email a PDF copy of this form to our office.