Perkins Chiropractic
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New Patient Form

Before beginning this document please be sure to have a printer attached to your computer. For security reasons, this file cannot be saved.

Patient Information

Date of First Appointment

Last Name | First Name | Middle Initial | SSN

Address | City | State | Zip Code

☐ Male ☐ Female Date of Birth | Phone Number | Work Number

Your Employer | Occupation

Business Address | City | State | Zip Code

Are You: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Spouse's or Parent's Name | Employer | Work Number

Emergency Contact | Phone Number

Responsible Party

Name of the person responsible for this account | SSN

Relationship to the patient | Phone Number

Address | City | State | Zip Code

Name of Employer | Work Phone Number

Insurance Information

Name of the Insured | Relationship to the Patient

Date of Birth | SSN | Date Employed

Name of Employer | Work Phone Number

Address | City | State | Zip Code

Insurance Company | Phone Number

Group Number | Employer Number

Insurance Address | City | State | Zip Code

How much is your deductible? | How much have you used? | Max annual benefit

Symptoms

Reason for Visit

When did you first notice symptoms?

Is this condition getting progressively worse?

Specifically, where are the problem(s) located?

Which activities are difficult to perform? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down Other

Type of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Other

Rate the severity of your pain: (1 for mild discomfort to 10 for Severe Pain) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Is the pain constant or does it come and go?

What treatment have you already recieved for your condition? ☐ Medication ☐ Surgery ☐ Physical Therapy Other

Name of doctor(s) who have treated your condition

Address City State Zip Code

Health History

Check only those conditions which are applicable:

☐ AIDS/HIV	☐ Cataracts	☐ Hepatitis	☐ Osteoporosis	☐ Suicide Attempt
☐ Alcoholism	☐ Chemical Dependency	☐ Hernia	☐ Pacemaker	☐ Thyroid Problems
☐ Allergy Shots	☐ Chicken Pox	☐ Herniated Disc	☐ Parkinson's Disease	☐ Tonsillitis
☐ Anemia	☐ Depression	☐ Herpes	☐ Pinched Nerve	☐ Tuberculosis
☐ Anorexia	☐ Diabetes	☐ High Cholesterol	☐ Pneumonia	☐ Tumors, Growths
☐ Appendicitis	☐ Emphysema	☐ Kidney Disease	☐ Polio	☐ Typhoid Fever
☐ Arthritis	☐ Epilepsy	☐ Liver Disease	☐ Prostate Problems	☐ Ulcers
☐ Asthma	☐ Fracturess	☐ Measles	☐ Prosthesis	☐ Vaginal Infections
☐ Bleeding Disorders	☐ Glaucoma	☐ Migraine Headaches	☐ Psychiatric Care	☐ Venereal Disease
☐ Breast Lump	☐ Goiter	☐ Miscarriage	☐ Rheaumatoid Arthritis	☐ Whooping Cough
☐ Bronchitis	☐ Gonorrhea	☐ Mononucleosis	☐ Rheumatic Fever	Other
☐ Bulimia	☐ Gout	☐ Multiple Sclerosis	☐ Scarlet Fever	
☐ Cancer	☐ Heart Disease	☐ Mumps	☐ Stroke	Other

Dates of last exams

Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control? ☐ Yes ☐ No

List any types of surgeries which you have had and the dates which they occured:

Please list all medications you are currently taking:

Allergies:

Daily Habits

What type of exercise do you perform on a daily basis? ☐ None ☐ Moderate ☐ Heavy

What do you daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work)

What vitamins do you currently take?

What kind of other nutritional supplements do you take?

Do you smoke? ☐ Yes ☐ No How much per day?

How much liquor do you consume on a weekly basis?

How much coffee or caffeinated beverages do you consume on a daily basis?

Whom may we thank for referring you?

Assignment and Release

I certify that I, and/or my dependent(s) have insurance coverage with and assign directly to Dr. Perkins / Perkins Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Perkins / Perkins Chiropractic may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of patient (or parent if a minor) _____ Current Date

Once this document has been filled with your information it cannot be saved. This protects your health records from ever being viewed by a third party. To maintain this record it must be printed. Please bring this printed copy to your first appointment or fax the document to 417.885.1202. If you have any questions please call our office at 417.885.1200.

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