New Patient

Dr. Crystal's Chiropractic Care

419 N. Cody Rd., Le Claire, IA 52753 (563) 271-0226

Patient Name: _____ _____
First MI Last Nickname / Preferred Name

Date of Birth: _____/_____/_____ Gender: ▢ M ▢ F Height: ____ft.____in. Weight: _____lbs.

Address: _____
Street Apt. # City State Zip

Phone #: (_____)_____-_____ ▢ Cell ▢ Home Email: _____

May we contact you through text messages? ▢ Yes ▢ No Preferred Contact Method: ▢ Phone ▢ Email ▢ Text

Marital Status: ▢ Married ▢ Single ▢ Civil Union ▢ Widowed ▢ Divorced ▢ Separated

Spouse's Name: _____ Ages of Children: _____ _____ _____ _____ _____ _____ _____

Emergency Contact Name: _____ Phone #: (_____)_____-_____ Relationship: _____

Employment Status: ▢ Full Time ▢ Part Time ▢ Retired ▢ Unemployed ▢ Student

Current or most recent job: Employed by: _____ Occupation: _____

Physical aspects of your job (e.g. standing for hours, heavy lifting, desk work): _____

_____

Non-work related exercise (e.g. walking, weight-lifting): _____

How much water do you drink per day? _____ Do you eat fresh fruits and green vegetables every day? ▢ Yes ▢ No

How long has it been since you've received chiropractic care? _____

Previous Chiropractor's Name: _____ Phone #: (_____)_____-_____

How did you hear about us? ▢ Signs ▢ Phone book ▢ Ad ▢ Internet Referral: _____ Other: _____

Guardian Info (person responsible for patient): ▢ Patient ▢ Parent Other relation: _____

If patient is **not** the guardian, please enter the responsible party's information:

Name: _____ Birth date: _____/_____/_____ Phone #: (_____)_____-_____

Address: _____
Street Apt. # City State Zip

Insurance Policyholder's relationship to the patient: ▢ Self ▢ Spouse ▢ Parent Other: _____

If patient is **not** the policyholder, please enter the policyholder's information: ▢ Same as Guardian

Name: _____ Birth date: _____/_____/_____ Phone #: (_____)_____-_____

Address: _____
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What **primary concern** brings you into the office today? _____

Please **describe when and how** this ailment began: _____

Please list all of your past **Surgeries**:

Year: _____ Procedure: _____ Complications: _____

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Year: _____ Procedure: _____ Complications: _____

Year: _____ Procedure: _____ Complications: _____

Please list your past **Major Illnesses/Diagnoses/Traumas**:

_____

_____

_____

_____

Please list any **Allergies/Sensitivities**:

_____

Please list any **Medications or Supplements** you are currently taking:

_____ _____

_____ _____

_____ _____

Is there anything else I should know about you?

_____

_____

All information submitted is true to the best of my knowledge. I have read and I agree to all of the policies and procedures set forth within the Patient Health Information; Authorizations, Assignment of Benefits and Consent to Treat; and Notice of Privacy Practices (Rev 7/1/2013).

_____

Patient/Guardian Signature **Date**