

New Patient Information

Our purpose at **Grapevine Chiropractic** is to educate as many families as possible about the spinal condition known as **Vertebral Subluxation**. **Vertebral Subluxation** destroys an **Optimal Spine** and your ability to have **Optimal Health**. Your experience with our office will be one of healing and also one of learning the **Truth** about **Optimal Health and Healing**.

Please complete all questions

Name:	Today's Date:
Address:	
City/State/Zip:	
Home Phone:	Work/Cell:
Birth Date:	Social Security#:
Marital Status: S M D W	Email Address:
Your Employer:	Occupation:

Spouse's Name:	Spouse's Employer:
Children (Names & Ages):	
Favorite Hobbies:	
Who may we thank for referring you?	
When did you last see a chiropractor?	Dr's Name:

Are you here because of an auto or work injury? Auto Work	Date of Injury:
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List other doctors you have recently seen:	
Drugs Taken:	
Surgeries you have had:	
Ever diagnosed with cancer?	What type or kind?

Who is financially responsible for this bill?	
Preferred Method of Payment: Cash Check Credit Card	
Emergency Contact:	Phone Number:

Please Continue and Complete Back Side

A. The vast majority of our patients have experienced literally dozens of impacts that could cause Vertebral Subluxations. Help us discover a few of yours.

1. How many auto accidents have you been in? (Please Circle) 0 1-2 3-4 5+
2. Motorcycle Accidents? Y N
3. Which of the following sports have you been involved in? (Please Circle)
 Football Basketball Soccer Hockey Gymnastics Martial Arts Dance Wrestling Horseback Riding Skating
 Water Skiing Other _____
4. Have you ever (Please Check)

<input type="checkbox"/> Fallen Down the Stairs	<input type="checkbox"/> Slipped on Ice or Snow
<input type="checkbox"/> Has Stress or Strain While Working	<input type="checkbox"/> Had a Sports Injury
5. Do You Ever (Please Check)

<input type="checkbox"/> Sit More Than Four Hours a Day	<input type="checkbox"/> Drive More Than Two Hours a Day
<input type="checkbox"/> Work at a Computer More Than Two Hours a Day	

B. Subluxations can cause malfunction in any part of your body. Please check all the health complaints you are currently experiencing.

<input type="checkbox"/> Loss of smell	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Back stiffness/ Pain	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Numbness in fingers
<input type="checkbox"/> Loss of taste	<input type="checkbox"/> Recurring Infection	<input type="checkbox"/> Neck stiffness/ Pain	<input type="checkbox"/> Infertility	<input type="checkbox"/> Numbness in toes
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Tension/ Stress	<input type="checkbox"/> Jaw/ TMJ problems	<input type="checkbox"/> Menopause	<input type="checkbox"/> Cold hands/ feet
<input type="checkbox"/> Light sensitivity	<input type="checkbox"/> Depression	<input type="checkbox"/> Muscle pain	<input type="checkbox"/> Hot flashes	<input type="checkbox"/> Burning hands/ feet
<input type="checkbox"/> Dizziness/ Vertigo	<input type="checkbox"/> Nervousness/ Anxiety	<input type="checkbox"/> Headaches	<input type="checkbox"/> PMS	<input type="checkbox"/> Pins & Needles
<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Stomach upset	<input type="checkbox"/> Migraines	<input type="checkbox"/> Painful menstruation	<input type="checkbox"/> Sinus problems
<input type="checkbox"/> Buzzing/ Ringing in ears	<input type="checkbox"/> Heartburn/ Ulcers	<input type="checkbox"/> Allergies	<input type="checkbox"/> Problems Urinating	<input type="checkbox"/> Impotence
<input type="checkbox"/> Irritability	<input type="checkbox"/> Ear infections	<input type="checkbox"/> Sleep problems	<input type="checkbox"/> Diarrhea/ Constipation/ Excessive Gas	

C. Subluxations can put pressure on nerves for a long period of time. How long have you had the above complaint(s)? _____

D. Nerve Pressure and irritation can be constant or occasional. How often do you have the above complaints? _____

- E. Irritation to different nerve fibers can create different sensations. Is yours:
- | | | |
|------------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Achy | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Burning | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Tingling | |

F. Subluxations can cause a weakening of the entire spine. Is yours worse:

<input type="checkbox"/> In the morning	<input type="checkbox"/> All the time
<input type="checkbox"/> Late in the day	<input type="checkbox"/> Other
<input type="checkbox"/> At Night	

Please Note:

1. All first visit charges are payable/due when services are rendered.
2. The fee paid for x-rays is for analysis only. The film itself is the property of this office. Once the films have been used for treatment purposes they cannot be released. Copies may be made for your use (\$10 per copy).

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Grapevine Chiropractic will provide the necessary information to assist me in making collections for the insurance company and any amount authorized to be paid directly to Grapevine Chiropractic will be credited to my account.

I clearly understand and agree that I am personally responsible for payment due for services rendered.

Patient's Signature

Date

Guardian's Signature Authorizing Care for Minor

Date