

New Patient Introduction

Name _____ What should we call you? _____

Address _____
(Street) (City/Town) (State) (Zip Code)

Sex _____ Date of Birth _____ S.S. # _____

Phone (home) _____ (cell) _____ (work) _____

E-Mail: _____

We send out a FREE monthly e-mail newsletter that reviews the latest science on healthy living.
Do you want to receive it?

- Yes, please send me the FREE e-mail updates.
- No, I don't want to know how to get and stay healthy!



Referred to our office by: _____

May we thank that person for referring you? Yes No

If this visit is for a child, name of parent or legal guardian _____

I give permission for this child to be seen at Hadley Chiropractic _____
(signature)

If you have a general medical practitioner to whom you would like us to send a summary of findings and recommendations for care, please list that name and address (if you know it) below:

What is the general reason for this visit?

Please sign or initial to indicate that you received
our HIPPA "Privacy Protection" statement.

_____ Date _____

Confidential Health Questionnaire

Have you ever received chiropractic care before? Yes No

If yes, why?

When was your most recent spinal adjustment? _____
How would you describe your previous chiropractic care?

Please list all medications you are taking:

Please list any surgeries that you have had:

Please check off any health problems that you have had:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> allergies | <input type="checkbox"/> cancer | <input type="checkbox"/> digestive | <input type="checkbox"/> skin conditions |
| <input type="checkbox"/> blood pressure | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> urinary tract | <input type="checkbox"/> eyes |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> epilepsy | <input type="checkbox"/> prostate | <input type="checkbox"/> difficulty sleeping |
| <input type="checkbox"/> low blood sugar | <input type="checkbox"/> osteoporosis | <input type="checkbox"/> thyroid | <input type="checkbox"/> fibromyalgia |
| <input type="checkbox"/> lungs/respiratory | <input type="checkbox"/> arthritis | <input type="checkbox"/> cholesterol | <input type="checkbox"/> headaches |

Please list any other health problems that you have had:

Do you smoke? Yes No

Do you exercise regularly? Yes No

If yes, please briefly describe your exercise program:

Women only:

Number of full-term pregnancies _____

Is there any chance that you are now pregnant? Yes No

Signed _____ Date _____