New Patient Application & History

1 Patient Information

Date _____

Patient SSN _____

Patient Name _____
First Name Middle Initial Last Name

Address _____

City _____ State _____ Zip _____

Email _____ We will never share your e-mail with any third parties.

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced

Partnered for _____years

Number of Children ___ Employer/School _____

Employer/School Phone (_____)_____

Occupation _____

Spouse's Name _____

Who may we thank for referring you? _____

Have you ever received chiropractic care before? ☐ Yes ☐ No

If yes, who was your chiropractor? _____

What kind of results did you have? _____

_____

Do you have a primary provider (MD)? ☐ Yes ☐ No

If yes, who is your doctor? _____

Where is he/she located? _____

2 Insurance Information

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Noah Marchese all insurance benefits, if any, otherwise payable to me for services rendereed. 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 submissons.

The above-named doctor may use my health care informatin 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. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Represenative

_____
Print name of Patient, Parent, Guardian or Personal Represenative

_____ _____
Date **Relationship to Patient**

3 Phone Numbers

Home (_____)_____ Cell (_____)_____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____Relationship _____

Home (_____)_____Work (_____)_____

4 Accident Information

Is condition due to an accident? ☐ Yes No Date _____

Type of accident Auto ☐ Work ☐ Home ☐Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp Other

Attorney Name (if applicable) _____

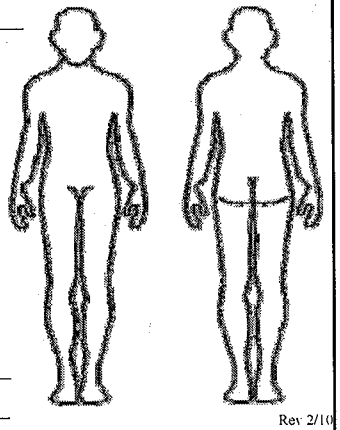
5 Current Complaints

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continute to have pain, numbness or tingling ——————>



Rate the severity of your pain on a scale from 0 (no pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching Shooting ☐ Burning
☐ Tingling Cramp ☐Stiffness ☐Swelling ☐Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine Recreation
Activities or movements that are painful to perform ☐ Sitting ☐Standing Walking ☐Bending ☐Lying Down

Is there anything you do that makes it feel better? _____ Worse? _____

Does the pain shoot or radiate anywhere? _____

6 Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy
Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
Spinal Exam _____ Chest X-Ray _____ Urine Test _____
Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Cirlce "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	Yes	No	Diabetes	Yes	No	Liver Disease	Yes	No	Rheumatic Fever	Yes	No
Alcoholism	Yes	No	Emphysema	Yes	No	Measles	Yes	No	Scarlet Fever	Yes	No
Allergy Shots	Yes	No	Epilepsy	Yes	No	Migraine Headaches	Yes	No	STD	Yes	No
Anemia	Yes	No	Fractures	Yes	No	Miscarriage	Yes	No	Stroke	Yes	No
Anorexia	Yes	No	Glaucoma	Yes	No	Mononucleosis	Yes	No	Suicide Attempt	Yes	No
Appendicitis	Yes	No	Goiter	Yes	No	Multiple Sclerosis	Yes	No	Thyroid Problems	Yes	No
Arthritis	Yes	No	Gonorrhea	Yes	No	Mumps	Yes	No	Tonsilitis	Yes	No
Asthma	Yes	No	Gout	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Bleeding Disorders	Yes	No	Heart Disease	Yes	No	Pacemaker	Yes	No	Tumors, Growths	Yes	No
Breast Lump	Yes	No	Hepatitis	Yes	No	Parkinson's Disease	Yes	No	Typhoid Fever	Yes	No
Bronchitis	Yes	No	Hernia	Yes	No	Pinched Nerve	Yes	No	Ulcers	Yes	No
Bulimia	Yes	No	Herniated Disc	Yes	No	Pneumonia	Yes	No	Vaginal Infections	Yes	No
Cancer	Yes	No	Herpes	Yes	No	Polio	Yes	No	Whooping Cough	Yes	No
Cataracts	Yes	No	High Blood Pressure	Yes	No	Prostate Problem	Yes	No	Other _____		
Chemical Dep.	Yes	No	High Cholesterol	Yes	No	Psychiatric Care	Yes	No			
Chicken Pox	Yes	No	Kidney Disease	Yes	No	Rheumatoid Arthritis	Yes	No			

EXERCISE
- None
- Moderate
- Daily
- Heavy

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS
- ☐Smoking Packs/Day _____
- ☐Alcohol Drinks/Week_____
- ☐Coffee/Caffeine Drinks Cups/Day_____
- ☐High Stress Level Reason_____

Are you pregnant? ☐Yes ☐No Due Date _____

Injuries/Surgeries you have had:	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7 Medications

Allergies

Supplements

FAMILY HEALTH HISTORY

Patient _____ Date _____

Please review the below listed diseases and conditions and indicate those that are current health problems of a family member by the designation C under his or her column. The designation P should be used to indicate a past problem. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form.

CONDITION	FATHER AGE ____	MOTHER AGE ____	SPOUSE AGE ____	BROTHER(S) AGE ____	BROTHER(S) AGE ____	SISTER(S) AGE ____	SISTER(S) AGE ____	CHILDREN AGE ____	CHILDREN AGE ____	CHILDREN AGE ____
Arthritis										
Asthma-Hay Fever										
Back Trouble										
Bursitis										
Cancer										
Constipation										
Diabetes										
Disc Problem										
Emotional Problems										
Emphysema										
Epilepsy										
Headaches										
Heart Trouble										
High Blood Pressure										
Insomnia										
Kidney Trouble										
Liver Trouble										
Migraine										
Nervousness										
Neuritis										
Pinched Nerve										
Scoliosis										
Sinus Trouble										
Stomach Trouble										
Other:										

If any of the above family members are deceased, please list their age at death and cause: _____

_____

_____

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8 Informed Consent For Chiropractic Treatment

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

_____
Printed name of Patient or Representative

x_____ _____
Signature of Patient or Representative Date

9 Receipt of Privacy Notice

My signature, below, certifies that I have received a copy of the NOTICE OF PRIVACY PRACTICES.

x_____ _____
Signature of Patient or Representative Date