



APPLICATION FOR NEW PATIENT STATUS

Today's Date: _____ How were you referred to our office? _____

Name: _____ Sex: Male Female

Birthdate: _____ Age: _____ Height _____ Weight _____

Driver's License #: _____ Social Security #: _____

Home Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

Are you a member of the armed forces? Yes No If yes, how long are you stationed in this area? _____

Employer: _____ Occupation: _____

Work Address: _____ City/State/Zip: _____

Work Phone: _____ Marital Status: Single Married Divorced Widowed Living With

Spouse's Name: _____ Spouse's Occupation: _____

Number of Children: _____ Children's Name/Ages: _____

Name of your family physician: _____ City they are located in: _____

Past Chiropractic Care? Yes No If yes, date of last visit? _____ Chiropractor's Name: _____

If you are experiencing ANY health problems, please list your chief complaints in order of severity (pain, symptoms, etc.)

1. _____ For how long? _____

2. _____ For how long? _____

3. _____ For how long? _____

4. _____ For how long? _____

Has this problem been getting: better worse staying the same

Currently or in the past have you ever experienced any of these complaints while working? Yes No If yes, please describe what activities at work may cause you to experience these complaints: _____

Are there any other activities, incidents, or events outside of work that may cause these complaints? Yes No If yes, please explain: _____

Have you at any time in the past ever suffered a work injury? Yes No If yes, what is the date of injury? _____

Do you have an attorney for this work injury? Yes No If yes, who is your attorney? _____

Have you been involved in a car accident in the last 12 months? Yes No If yes, what is the date of the car accident? _____

Do you have an attorney for this car accident? Yes No If yes, who is your attorney? _____

How many other passengers were in the car with you during the accident? _____

List other doctors consulted for these conditions: 1. _____ 2. _____

Have you had any surgeries or hospitalizations? Yes No If yes, please list each with date of surgery/hospitalization: _____

Please list any current or past injuries and illnesses that are not listed above: _____

Please list all medications (prescription or over-the-counter) you are currently taking: Aspirin/Tylenol Pain killer Muscle relaxers

Insulin Tranquilizers Birth Control Pills Antihistamines Antacids Others _____

Health Insurance: _____ Policyholder: _____

Spouse's health insurance (if applicable): _____ Policyholder: _____

Spouse's health insurance claims address: _____

HEALTH CONDITION RATING SCALE

The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing). We would like to know how much your health condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

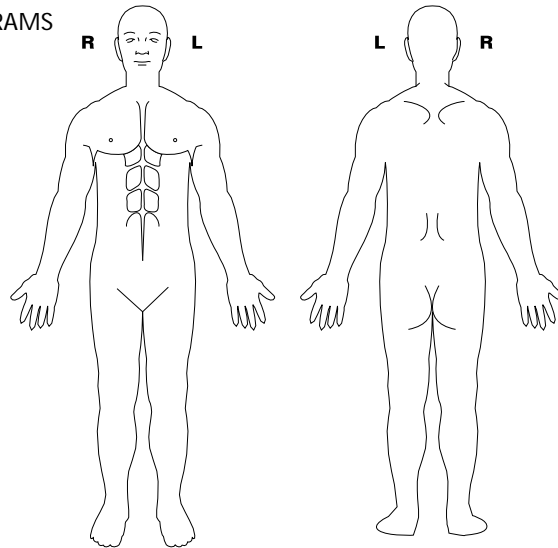
Completely able to function
0
1
2
3
4
5
6
7
8
9
10
Totally unable to function

For each of the six categories of daily living, **PLEASE CIRCLE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES DISRUPTION**. 0 means no disability at all and 10 means all activities that you would normally be involved have been totally disrupted by your health condition (pain and/or symptoms you may be experiencing).

1. FAMILY/HOME RESPONSIBILITIES: activities related to the home or family including chores and duties around the house (yardwork, doing dishes, errands, favors for family, driving kids to school, etc.) 0 1 2 3 4 5 6 7 8 9 10
2. RECREATION: hobbies, sports and other similar leisure time activities. 0 1 2 3 4 5 6 7 8 9 10
3. SOCIAL ACTIVITY: activities which involve participation with friends and acquaintances other than family members including parties, theatre, concerts, dining out, and other social functions. 0 1 2 3 4 5 6 7 8 9 10
4. OCCUPATION: activities that are a part of or directly related to one's job including non-paying jobs as well, such as that of a homemaker or volunteer worker. 0 1 2 3 4 5 6 7 8 9 10
5. SELF CARE: activities which involve personal maintenance and independent daily living (taking a shower, getting dressed, driving, etc.). 0 1 2 3 4 5 6 7 8 9 10
6. LIFE SUPPORT ACTIVITY: basic life supporting behaviors such as eating, sleeping and breathing. 0 1 2 3 4 5 6 7 8 9 10

If you are experiencing any health problems, **PLEASE MARK THE EXACT LOCATION OF YOUR PAIN ON THE DIAGRAM BELOW**. Also, describe the type and frequency of your pain. For example, dull, sharp, constant, off and on, when standing, sitting, walking, etc.

COMPLETE THESE DIAGRAMS



I understand that all services are to be PAID IN FULL on the day of service unless other arrangements have been made and agreed to in writing. If I have insurance, BEND CHIRPORACTIC CENTER will submit a claim on my behalf. I realize that the insurance company may not cover the full amount of services rendered and that I am responsible for that balance, except where provider discounts apply. I authorize payment of medical benefits directly to BEND CHIROPRACTIC CENTER.

Method of payment for today's charges: CASH CHECK CREDIT CARD

PLEASE NOTE: Not all patients require x-rays to determine type of care and length of care. If your examination warrants x-ray analysis, the following office policy prevails:

1. All first visit charges are payable when services are rendered.
2. The fee paid for x-rays is for analysis only. California State Law requires we maintain your x-rays. The film itself is the property of Bend Chiropractic Center. Films may be loaned to another facility with authorization only.

Signature of patient (or parent/guardian) _____ Date _____