New Patient Demographics

Patient Data

Title:____ First Name:_____ Middle Initial:____ Last Name:_____

Preferred to be called:_____

Address line 1:_____

Address line 2:_____

City:_____ St:____(two letter abbreviation) Zip Code:_____

Home Phone: (____)____-_____ Work Phone: (____)____-_____ Cell Phone: (____)____-_____

Email Address:_____ Date of birth: ____/____/____

Sex: ☐ Male ☐ Female Social Security #:_____

Marital Status: ☐ Single ☐ Married ☐ Other (check one)

Employment Status: ☐ Employed ☐ Full time student ☐Part time student ☐Other (check one)

Spouse Data

Is your spouse a patient in the clinic? ☐ Yes ☐No

First name:_____ Middle Initial:____ Last Name:_____

Home Phone: (____)____-_____ Work Phone: (____)____-_____ Spouse D.O.B:____/____/____

Spouse SS#: _____

Employer Data

Name:_____

Address line 1:_____

Address line 2:_____

City:_____ St.____ (two letter abbreviation) Zip Code:_____

Insured's data

First Name:_____ Middle Initial:_____ Last Name:_____

Home Phone: (____)____-_____ Work Phone: (____)____-_____ Spouse's D.O.B:____/____/____

Spouse's SS#:_____ Relationship to insured:_____

Employer:_____

Emergency Contact

Contact Name: _____

Contact Phone: (____)____-_____

Is it ok to call you at work? ☐ Yes ☐ No

How did you hear about our clinic?

☐ Family member	☐ Attorney	☐ Internet website	☐ Health class
☐ Friend	☐ Yellow Pages	☐ Billboard	☐ Brochure
☐ Physician	☐ Newspaper Ad	☐ TV Commercial	☐ Direct mail ad
☐ Employer	☐ Sign on building	☐ Radio	☐ Other

If you selected "Yellow Pages" please indicate which yellow pages:

_____ _____ _____

If you selected "family member", "friend", or "physician" please enter their name below:

_____

If you selected "other" please describe:

_____

Medical conditions:

☐ Arthritis	☐ Cancer	☐ Diabetes	☐ Heart Disease
☐ Hypertension	☐ Psychiatric Illness	☐ Skin disorder	☐ Stroke

Surgeries:

☐ Appendectomy	☐ Cardiovascular procedure	☐ Cervical disk procedure	☐ Hysterectomy
☐ Joint replacement	☐ Laminectomies	☐ Radical prostatectomy	☐ Transuretheral prostate surgery

Allergies:

☐ Eggs	☐ Fish & Shellfish	☐ Milk or Lactose	☐ Peanuts
☐ Soy	☐ Sulfites	☐ Wheat/gluten	

Social History:

☐ Caffeine used occasionally	☐ Caffeine used often	☐ Chew tobacco occasionally	☐ Chew tobacco often
☐ Drink alcohol occasionally	☐ Drink alcohol often	☐ Exercise not at all	☐ Exercise occasionally
☐ Exercise often	☐ Experience stress occasionally	☐ Experience stress often	☐ Smoke 1 pack or less a day
☐ Smoke more than 1 pack daily	☐ Wear seat belt always	☐ Wear seat belts never	☐ Wear seatbelts usually

Family History:

☐ Arthritis(parent)	☐ Arthritis(sibling)	☐ Cancer(parent)	☐ Cancer(sibling)
☐ Cholesterol(parent)	☐ Cholesterol(sibling)	☐ Diabetes(parent)	☐ Diabetes(sibling)
☐ Heart problems(parent)	☐ Heart problems(sibling)	☐ High blood pressure(parent)	☐ High blood pressure(sibling)
☐ Psychiatric(parent)	☐ Psychiatric(sibling)	☐ Stroke(parent)	☐ Stroke(sibling)
☐ Thyroid(parent)	☐ Thyroid(sibling)		

Substance Use:

☐ Alcohol(past)	☐ Alcohol(present)	☐ Amphetamines(past)	☐ Amphetamines(present)
☐ Barbiturates(past)	☐ Barbiturates(present)	☐ Cocaine(past)	☐ Cocaine(present)
☐ Crystal meth(past)	☐ Crystal meth(present)	☐ Heroine(past)	☐ Heroine(present)
☐ Marijuana(past)	☐ Marijuana(present)		

Male Children:

☐ Under 6 years	☐ Under 10 years	☐ Under 19 years

Female Children:

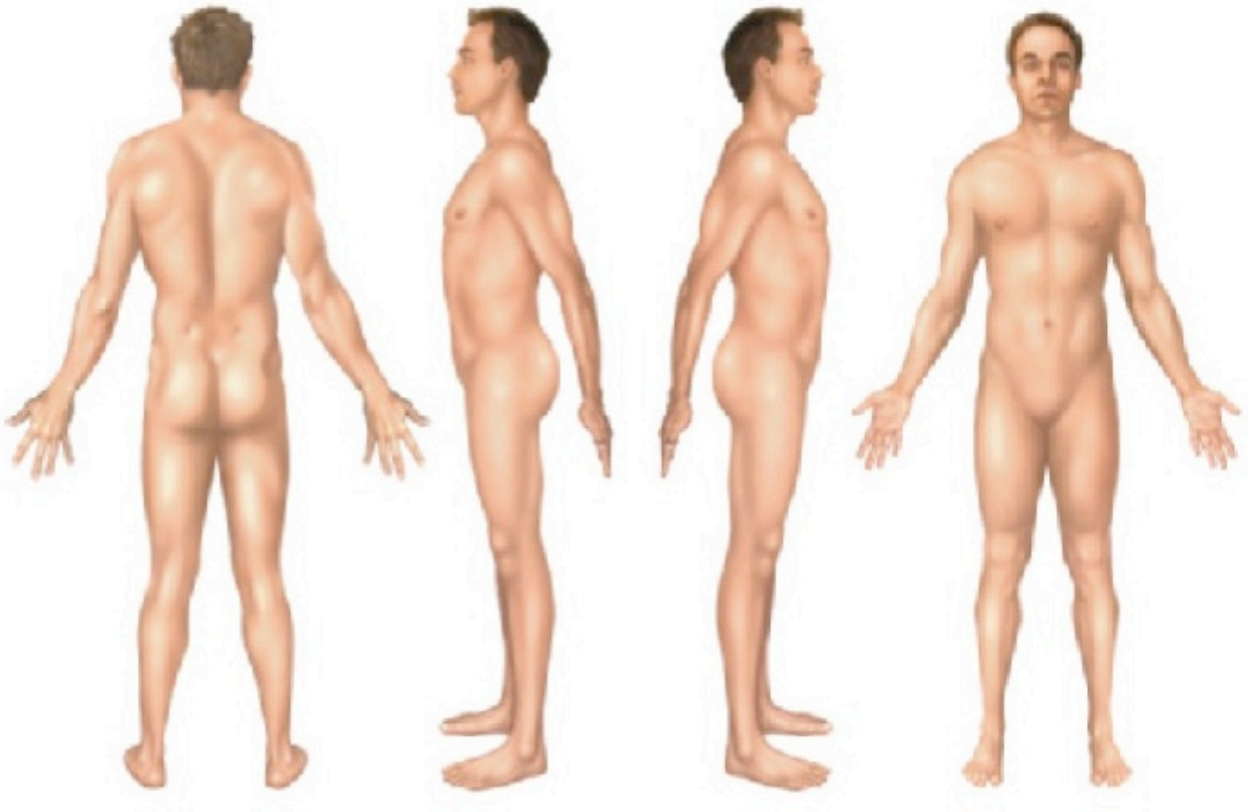
☐ Under 6 years	☐ Under 10 years	☐ Under 19 years

Occupational activities:

☐ Administration	☐ Business owner	☐ Clerical/secretarial	☐ Computer user
☐ Construction	☐ Daycare/childcare	☐ Executive/legal	☐ Food service industry
☐ Health care	☐ Heavy equipment operator	☐ Heavy manual labor	☐ Home services
☐ Household	☐ Light manual labor	☐ Manufacturing	☐ Medium manual labor

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

 # = Numbness **X = Burning** **/ = Stabbing** **0 = Pins & needles** **+ = Dull Ache**



Describe your symptoms:_____

_____

When did your symptoms start? Month_____ Day_____ Year_____

How did your symptoms begin?_____

_____

How often do you experience your symptoms?

☐Constantly (70-100% of the day) ☐Frequently (51-75% of the day) ☐Occasionally (26-50% of the day) ☐Intermittently (0-25% of the day)

What describes your symptoms?

☐Sharp ☐Dull ache ☐ Numb ☐ Shooting
☐Burning ☐Tingling ☐ Stabbing

How are your symptoms changing?

☐Getting better ☐Not changing ☐ Getting worse

During the past 4 weeks, indicate the average intensity of your symptoms: (0 = none to 10 = Unbearable)

☐0 None ☐ 1 ☐ 2 ☐ 3
☐4 ☐ 5 ☐ 6 ☐ 7
☐8 ☐ 9 ☐ 10 Unbearable

During the past 4 weeks, how much pain has interfered with your normal work (including both work outside home and housework):

☐Not at all ☐ A little bit ☐ Quite a bit
☐Extremely ☐ Moderately

During the past 4 weeks, how much of the time has your condition interfered with your social life activities?
☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time
☐ None of the time

In general, would you say your overall health right now is..
☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Who have you seen for your symptoms?
☐ No one ☐ Other Chiropractor ☐ Medical Doctor ☐ Physical Therapist ☐ Other

What treatment did you receive for your symptoms?
☐ Adjustments ☐Physical Therapy ☐ Medication ☐ Surgery ☐Other

When did you receive this treatment?
☐ In the last month ☐ 2-3months ago ☐ 3-6 months ago ☐ 6 months to a year ago
☐ 1-2 years ago ☐2-5 years ago ☐ 5-10 years ago

What tests have you had for your symptoms?
☐ X-rays ☐ MRI ☐CT Scan ☐ Other

When were these tests done?
☐ In the last month ☐ 2-3months ago ☐ 3-6 months ago ☐ 6 months to a year ago
☐ 1-2 years ago ☐2-5 years ago ☐ 5-10 years ago

Have you had similar symptoms in the past?
☐ Yes ☐ No

Have you seen treatment in the past for the same or similar symptoms, who did you see?
☐ This office ☐ Other Chiropractor ☐ Medical Doctor ☐ Physical Therapist ☐Other

What is your occupation?
☐ Professional/Executive ☐White collar/Secretarial ☐ Tradesperson ☐ Laborer
☐ Homemaker ☐ Full time Student ☐ Retired ☐Other

If you are not retired, a homemaker or a student, what is your work status?
☐ Full-time ☐ Part time ☐ Self-Employed ☐ Unemployed
☐ Off work ☐ Other

Who is your primary physician?_____

Name of clinic_____ Phone #_____

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. I also give this power of attorney to endorse checks made out to me to be credited to my account. However, I clearly understand and agree that all services rendered me are charged directly to my and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Release of Information

In the event that Dr. Berkowitz believes it is necessary for a second opinion or finds it necessary to contact my primary or treating physician, I authorize this office to release my medical records arising from said treatment.

_____ **Patient/Guardian Initial**

Assignment of Proceeds

I hereby direct all payers to release any information regarding any coverage or benefits to pay directly to Carolina Chiropractic Plus. I authorize this office to release any information to insurance carries regarding my treatment to facilitate collection.
I agree that all provisions to this agreement are reasonably necessary for the protection of the rights and interests of Carolina Chiropractic Plus and myself.

_____ **Patient/Guardian Initial**

Patients Signature: _____ Date_____

Guardian or Spouse's Signature authorizing care:_____