CHIROPRACTI Bringing Out The Best In You

New Patient
Welcome To Our Office

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Name	Prefer	red name_	-12-		
Address					
City/State/Zip				111	
Phone #s (home)		(cell)			
Is it okay to contact you at work? O no					
E-mail address	_ Web sit	e			
SS#					
OccupationEmpl	oyer				
Marital status O single O mar					
Spouse's name	Phone #(s	s)			
Children's names and ages					N. N.
Do you have any pets? O no O yes					
Emergency contact: Name					
Relationship					
Favorite hobbies or interests					
What Brings You Here?					
Have you ever had chiropractic care bef	ore?	0	no	O yes	
If yes, please tell us the doctor's name_					
Were you pleased with your care?		0	no	O yes	
How did you find out about our office?_		garante i			
Is this appointment related to O	work	0	spo	rts	O auto
0	personal	injury O	oth	er	
When did the incident occur?					
Attorney (if applicable)		Phone _			
Are you receiving care from other health	h professio	onals?	no	O yes	
If yes, please name them and their spec	ialty	Table 1			
Please list any drugs or medications you	ı are takin	g			
Please list any vitamins/herbs/homeopa	thics/othe	r you are ta	king		
Are you pregnant?	no O v	oc If	MOC	what mon	th2

Where is the problem? Please use the illustrations and lines below to explain. O Front O Back O Back Do you have O pain O numbness O tingling O aches Is your pain O sharp O dull O throbbing O constant O inte Are your symptoms O sitting O standing O walking affected by O bending O lying down O weather Please explain Do you feel O cramps O burning O other O swelling O stiffness O byour symptoms O work O sleep O other Interfere with O day-to-day activities O play On a scale of 1-10 (1 least, 10 most), please rate:	ent Health				
Is it	are your most pressing	health concerns?			
Is it	ovy long?				
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Do you have	_			- 10	
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The severity of your symptoms 1 2 3 4 5 6 7 8 9 10	eventy of your sympton	1 2	3 4 5 6 7	0 9 10	

Health History

Do you have, o	r have you had,	any of the following	(please check 🕉	all that apply)		
O pneumonia	O mumps	O influenza	O rheumatic fev	COLUMN TO SERVICE THE SERVICES		
O pleurisy	O polio	O chickenpox	O thyroid diseas			
O epilepsy	O cancer	O depression	O whooping cou			
O eczema	O measles	o arthritis	heart disease	O rashes		
If you have eve	r been diagnose	ed with another dise	ease or condition,	please describe		
Do you use	o coffee	tea O	artificial sweetene	ers O sugar		
	O alcohol	cigarettes O	recreational drugs			
Have you ever	suffered from (p	lease check of all t	hat apply)			
O neck pain		o stuffy nose	O disc	olored urine		
O low back pa	in	allergies	O gas/	bloating after meals		
O headache		o fainting	O hear	rtburn		
o migraines		O weight loss	O colit	is		
o arm back/tir	ngling	O poor appetite	o irrita	o irritable bowel		
O shoulder pai	in	 excessive app 	etite O blac	black or bloody stools		
o hand pain/tingling		O nervousness	O cons	O constipation		
O leg pain/tingling		O confusion	O hem	O hemorrhoids		
O jaw pain		O depression	O liver	O liver problems		
O chest pain		dental probler	ns O strol	O stroke		
O lung problems		O excessive thir	st o para	lysis		
O heart proble	ms	o frequent naus	ea O ting	o tingling		
O abnormal ble	ood pressure	O vomiting	O num	o numbness		
O irregular hea	artbeat	o prostate probl	em O fatig	O fatigue		
o ankle swelli	ng	O breast pain/lu	mp O dizz	o dizziness		
O cold extremi	ties	O cramps	O loss	O loss of sleep		
O blurred visio		painful urinati	on O diffic	culty hearing		
O vision proble	ems	o bladder troubl	e O ear p	oain		
O difficulty bre	eathing	O excessive urin	ation			
If applicable, da	ate of last menst	rual period	fbufting			
Past injuries ca	n affect present	health (please chec	k & all that apply	7)		
o falls/acciden	its	O head injuries	O fight	S		
o sports injuri	es	O broken bones	O dislo	ocations		
O spinal tap		O surgery	O tract	ion		
O use(d) a can	e or walker	O extensive den	tal work O dent	al appliances		
O knocked und	conscious					
If yes to any of	the above. pleas	se describe				
	or or or other property of the second of th	en en constituir et a constituir et a de la c				

What Do You Know About Chiropractic?

In your own words, what do chiropractors do?	
Do you know what spinal nerve stress/ subluxation is? Yes No If yes, please describe	
Do any friends or relatives see chiropractors? Yes No If yes, do they use chiropractic for Health Maintenance/optimization Health pro	blems
Are you seeking chiropractic for Health Maintenance/optimization Health pro	blems
Are there other health concerns or anything else you'd like us to know about you? If yes, tell us.	please
Financial Responsibility Who is responsible for payment? How will you pay for your care? (Check) (Cash) (Credit Card) Insurance Co Group Policy #	
Address City State Zip Code_	
Phone # () Name of Insured DOB/	
Relation Insured's Employer	
Office Policies: If I am accepted as a patient of Dr. Marcus S. Ettinger DC, BSc I agree for all services, including services not covered by my insurance company. In the event receive checks from my insurance company or from Third-Party insurance for services at Advanced Healing Arts Institute, I understand that I am to sign the checks over the Healing Arts Institute immediately. If I suspend (or terminate) my treatment without permission, it will be understood that I have reached maximum healing for my conditionagree to be fully responsible for my condition and future care. I understand that no records or x-rays will be released from this office if I owe any money on my account. Consent For X-Ray (If Needed): I authorize Advanced Healing Arts Institute to do examination if needed. Consent To Treat: I also understand that no cures are promised (or implied) and regarding care at this office will be explained to me upon my request. I now authorize Deproceed with any necessary treatment.	that I rendered to Advanced the doctor's n. I then medical an X-Ray
I have read Dr. Ettinger's office policies and consent to treat information, and I agree with the below:	m by signing
Signature: Date:	_
Parent/Guardian Signature: Date:	