706 Ridge Road, Munster, Indiana 46321 219/836-8890
12732 Wicker Avenue, Cedar Lake, Indiana 46303 219/374-4144

NEW PATIENT FORM

This information is confidential. If we do not sincerely believe your problem will respond favorably we will not be able to accept your case. We will refer you to disciplines we believe will help you. In order for us to understand your heath problems properly, please complete this form neatly, accurately and completely. Thank You.

CHECK BEST CONTACT OPTION

Name _____ Nick Name _____ ☐ E-Mail _____

S.S. # _____ Age _____ Birth Date _____ ☐ Cell Phone _____

Address _____ ☐ Home Phone _____

City, State, Zip _____ Marital Status S M W D How Many Children _____

Occupation _____ Employer _____ Office Phone _____

Work Address _____ City _____ State _____ Zip _____

Name of Wife/Husband/Parent(s) _____ Occupation _____

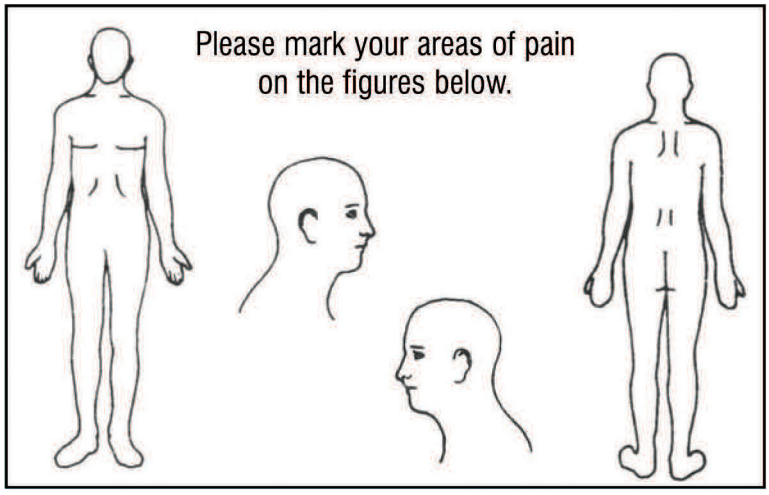
Employer _____ Office Phone _____

In case of emergency, nearest relative not living with you _____ Phone _____

How did you hear about us? _____

List present complaints, injuries and duration.

1. _____
2. _____
3. _____



Are these injuries related to a recent car/work/other accident? ☐ Yes ☐ No If Yes, please see receptionist.

List other doctors consulted for present complaints and injuries:

Name _____ When consulted _____

Diagnosis _____ Treatment _____

How long did you see the Doctor? _____ How frequently? _____

Results _____ May we send a report to this doctor? ☐ Yes ☐ No

Name _____ When consulted _____

Diagnosis _____ Treatment _____

How long did you see the Doctor? _____ How frequently? _____

Results _____ May we send a report to this doctor? ☐ Yes ☐ No

Present family doctor _____ Would you like us to send a report to your doctor? ☐ Yes ☐ No

Date of last physical examination _____ By Doctor _____

What surgeries have you had? _____

Type/When/Doctor/Remarks _____

_____

_____

List former serious accidents and falls: (auto, work , home, leisure, sports , other- circle one)

What/When/Symptoms/Treatment/Results _____

_____

_____

List broken bones: _____

What/When/Remarks _____

_____

_____

List medications and/or diet supplements you take: _____

What/Frequency/Doctor/Side Effects/Remarks _____

_____

_____

Do you have any diagnosed conditions?_____

Environment

Do any of your daily activities contribute to your present problem? _____

_____

Job _____

_____

Commute_____

_____

_____

Home Activities _____

_____

Leisure/Recreation/Sports_____

Other _____

What are your hobbies? _____

_____

Sports - Type/Frequency/Length of time?_____

_____

If you have discontinued sports or strenuous activities, why the change? _____

_____

Exert Yourself - Frequently/Occasionally/Rarely/Never? Describe how? _____

_____

Circle Current Conditions - Check Former Conditions

PRIMARY SYMPTOMS
MUSCULO-SKELETAL

Recurring Headaches
Eye or sinus pain
Facial spasms
Facial/jaw pain
Restricted movement-head/neck
Neck pain
Neck spasms
Poor posture
Upper back pain
Sore, aching "shawl" muscles
Pain-shoulder/arm/hand
Arthritis
Bursitis
Pain beneath/under shoulder blade
Pain around collar bone
Mid back pain
Chest pain
Rib cage pain
Pain beneath/below breast bone
Hiatal hernia
Restricted movement-torso
Scoliosis
Low back pain
Rheumatism
Neuritis
Neuralgia
Lumbago
Painful tailbone
Buttock pain
Hip pain
Sciatica
Swollen/painful/stiff joints- leg/foot
Restricted movement-leg/foot
Leg cramps
Leg pain-lower/upper
Foot/toe pain
Sore/weak muscles
Walking problems

CORRELATING SECONDARY SYMPTOMS

NERVOUS SYSTEM

Hot/cold spots
Numbness/tingling
Dizziness
Fainting
Paralysis
Convulsions
Nervousness
Personality Change
Anxiety
Irritability
Tremors
Tension
Insomnia
Depression
Confusion
Forgetfulness
Hiccups

EYE, EAR, NOSE & THROAT

Visual disturbances
Light sensitivity
Zig zag flashes
Eye strain
Eye inflammation
Visual problems
Chronic earache
Ear noises
Hearing loss
Ear discharge
Nose pain
Nose bleeding
Nose discharge
Difficulty breathing through nose
Sore mouth/gums
Canker sores
Dental problems
Difficulty speaking
Sinus trouble
Hay fever/allergies
Sore throat
Hoarseness
Head colds

RESPIRATORY

Difficulty breathing
Chronic cough
Coughing phlegm/blood
Asthma
Allergies
Chest colds
Tuberculosis

CARDIOVASCULAR

Heart attack
High blood pressure
Low blood pressure
Rapid beating heart
Slow beating heart
Pain over heart
Hardening of arteries
Swelling of ankles
Poor circulation
Stroke
Varicose veins

SKIN

Skin disorder
Acne
Shingles
Itching
Bruise easily
Dryness
Boils
Hives or allergies

GENERAL

Fever
Thyroid disorder
Chills
Diabetes
Sweats
Rheumatic fever
Chronic fatigue
Cancer
Loss of weight
Weight trouble

GASTRO-INTESTINAL

Chronic nausea
Vomiting
Vomiting blood
Food allergy
Poor appetite
Excessive hunger
Difficulty chewing/swallowing
Excessive thirst
Belching gas
Gastritis/heartburn
Pain over stomach
Ulcers/stomach disorder
Distention of abdomen
Constipation
Diarrhea
Colitis
Diverticulitis
Hemorrhoids
Liver trouble
Gall bladder trouble
Jaundice
Black stool
Bloody stool

GENITO-URINARY

Urine disorder-frequent/ excessive/scanty/painful/ discolored blood/pus
Bladder trouble
Kidney infection/stones
Impotency
Bed wetting
Prostatis

FEMALE

Periods-painful/excessive / irregular/cramps
Hot flashes
Breasts-lumps/congested
Menopause symptom

In order to help our patients obtain all insurance benefits for which they are eligible, we will need the following information.

Health Insurance Benefits (please complete in addition to Auto and Workmen's Comp. info).

Primary Company _____

Address _____

Deductible $ _____ Already paid ☐ Yes ☐ No ☐ Not Known

% Insurance Co. pays (if known) _____ Ins. ID# _____

Insured Name _____

Insured DOB _____ S.S. # _____

Other Company _____

Address _____

Deductible $ _____ Already paid ☐ Yes ☐ No ☐ Not Known

% Insurance Co. pays (if known) _____ Ins. ID# _____

Financial Responsibility Statement

I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. Furthermore , I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that , if I suspend or terminate my care and treatment , against the Doctor's recommendation , my account balance will be immediately due and payable.

Patient's Signature _____

S.S. # _____ Date _____

Other Responsible Party _____

S.S. # _____ Date _____

Information taken by _____

PLEASE COMPLETE FOR ALL PATIENTS 10 YEARS OLD AND YOUNGER

Chiropractic care during pregnancy _____

Problems during pregnancy _____

Problems during labor/delivery _____

Drugs during delivery _____

Type of birth: Normal Vaginal _____ Forceps _____ Breech _____ Cesarean _____

Birth took place: Home _____ Birthing Center _____ Hospital _____

Obstetrician/midwife _____ Pediatrician/Family MD _____

Immunization history _____

Purpose of this appointment _____

Has your child been treated on an emergency basis? ☐Yes ☐ No Describe _____

Childhood diseases ____ Chicken Pox _____Mumps ____ Measles

____ Rubella (German Measles) _____Whopping Cough

Medication (include non-prescription) _____ Surgeries _____

_____ _____

_____ _____

Has your child ever been involved in a car accident? ☐Yes ☐ No Was he/she injured? ☐Yes ☐ No

Explain _____

Has your child ever suffered from:

Dizziness	Bronchitis	Muscle jerking	Bed wetting	Convulsions
Tuberculosis	Backaches	Heart trouble	Broken bones	Neck problems
Digestive disorders	Hypertension/anxiety	Arthritis	Runs unevenly	Colds/flu
Poor appetite	Sinus trouble	Anemia	Diarrhea	Constipation
Paralysis	Hyperactivity	Hypoglycemia	Sleeplessness	Violent activity
Arm problems	Fainting	Diabetes	Asthma	
Allergies	Leg problems	Headaches	Neuritis	
Ruptures/hernias	Chronic earaches	Rheumatic fever	Orthopedic problems	

Other _____

Authorization for Care of Minor

I hereby authorize this clinic and its doctors to administer care as they so deem necessary to my son/daughter/ward.

Signed _____ Witness _____ Date _____

I realize that I am responsible for all fees charged by this clinic and that I will pay for all serves as they are performed. X-rays remain property of this clinic.

Signature _____ Date _____