

R. Tyler Given, D.C.
Family Chiropractor

New Patient Information

Name _____ What You Prefer to be Called _____
Home Phone (_____) _____ Cell/Other Phone (_____) _____
Address _____ City _____ State _____ Zip _____
Age _____ Birth Date _____ Marital Status M S W D How Many Children _____
Occupation _____ Employer _____
Work Phone (_____) _____ Name of Wife or Husband _____
Referred by _____ E-Mail _____

Health Information

Purpose of this visit _____
Other doctors seen for this condition _____
Have you been treated for any health condition during the past year? () Yes () No
Describe _____ Date of last physical exam _____
List any medications or drugs you take _____
List any surgeries you have had _____
List any serious illnesses you have had _____

Check any symptoms or problems you are having

- | | | |
|---|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Upper back pain or stiffness | <input type="checkbox"/> Low back pain or stiffness |
| <input type="checkbox"/> Neck pain or stiffness | <input type="checkbox"/> Arm pain or numbness | <input type="checkbox"/> Leg pain or numbness |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of strength in hands | <input type="checkbox"/> Loss of strength in legs |
| <input type="checkbox"/> Buzzing or ringing in ears | <input type="checkbox"/> Mid back pain or stiffness | <input type="checkbox"/> Stomach or bowel problems |
| <input type="checkbox"/> Loss of energy | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other _____ |

Additional information _____

Payment is expected at the time services are provided

Do you have chiropractic insurance benefits? () Yes () No () Don't Know

I understand and agree that I am personally responsible for all professional services received in this office. I understand that Dr. Given will provide me with forms to assist me in collecting from any insurance company. I authorize Dr. Given to release information regarding my care to insurance companies. I understand that if I suspend or terminate care, any and all fees will be immediately due and payable.

Patient Signature _____ SS# _____ Date _____
Information Taken By _____ Date _____