New Patient Registration

Thank you for choosing Lenz Chiropractic, PC for your chiropractic care. We appreciate your confidence in our services. Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. If you have any questions, please feel free to ask the front desk.

Have you ever received chiropractic care before? ❑ Yes ❑ No

Name of previous chiropractor and last treatment date: _____

Who may we thank for referring you? _____

How else did you hear about us? ❑ Phone Book ❑ Ad ❑ Health Care Professional _____ ❑ Other

Patient Information

Name: _____
(First) (Middle Initial) (Last) (Name Called By)

Address: _____

City: _____ State: _____ Zip Code: _____

Is this your mailing address? ❑ Yes ❑ No

Mailing Address (If different from above): _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Best way to reach you: ❑ Home ❑ Cell ❑ Work ❑ Email

Birthday: _____ Age: _____ SSN: _____

❑ Male ❑ Female ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Occupation: _____ Employer: _____

Parents Name (if a minor): _____ Spouse's Name: _____

# of Children: ___ Name(s): _____

In case of emergency, contact: _____

Relationship to you: _____ Phone: _____

Billing Information

Do you have insurance you would like us to bill? ❑ Yes ❑ No

Relationship to Patient: _____ Insurance Company: _____

Insurance ID Number: _____ Group/Claim Number: _____

Do you have other insurance besides the one listed above? ❑ Yes ❑ No

Relationship to Patient: _____ Insurance Company: _____

Subscriber Name and Number: _____

Group Number: _____ Birthday of Subscriber: _____

Accident Information (If Applicable)

Is your condition due to an accident? ❑ Yes ❑ No

Type of accident? ❑ Automobile ❑ Work ❑ Home ❑ Other: _____

To whom have you reported the accident? ❑ Insurance ❑ Worker's Comp ❑ Employer ❑ Other

Attorney Name (If applicable): _____

Your Condition

What do you believe is wrong with you? _____

What is your major concern/symptom/problem? _____

When did it begin? _____

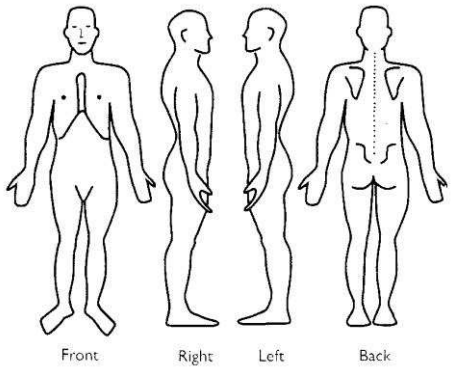
Have you had this problem before? ❑ Yes ❑ No

Is your condition getting progressively worse? ❑ Yes ❑ No

Is this problem ❑ constant ❑ comes and goes

How does it feel? ❑ dull ❑ aching ❑ sharp ❑ burning

❑ shooting ❑ stiff ❑ tingling ❑ throbbing ❑ numb ❑ other



Please show me where you are experiencing pain and/or discomfort

Circle below the severity of your pain or symptom on a scale of 0 to 10: (No pain) **0 1 2 3 4 5 6 7 8 9 10** (Severe pain)

What makes your condition better? _____

What makes your condition worse? _____

Does your condition interfere with your ❑ work ❑ sleep ❑ daily routine ❑ recreation ❑ other

Activities and/or movements that is painful to perform:

❑ sitting ❑ standing ❑ walking ❑ bending ❑ lying down ❑ getting up ❑ driving ❑ reading

Health History

What other treatments have you had for this condition?

❑ Chiropractic ❑ Orthopedic ❑ Neurologist ❑ Physical Therapy ❑ Medication ❑ Surgery ❑ None ❑ Other

Date of Last: Physical Exam: _____ Spinal X-Ray: _____ MRI: _____

Spinal Exam: _____ CT Scan: _____

List any medications you are taking: ❑ Muscle relaxers ❑ Pain killers ❑ Blood pressure ❑ Blood thinners ❑ Insulin ❑ Other: _____

Supplements/Vitamins/Herbs/Minerals: _____

Major accidents or falls: _____

Broken Bones: _____

Major Surgery/Operations: ❑ Appendectomy ❑ Back Surgery ❑ C-Section ❑ Gall Bladder ❑ Hernia ❑ Tonsils

❑ Other _____

Hospitalization (other than above): _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We need all the facts about your health history before we accept your case. ***THIS IS A CONFIDENTIAL HEALTH REPORT***.

GENERAL

NOW PAST

- ❑ ❑ Convulsions
- ❑ ❑ Dizziness
- ❑ ❑ Fainting
- ❑ ❑ Fever
- ❑ ❑ Headache
- ❑ ❑ Loss of sleep
- ❑ ❑ Loss of weight

MUSCLE & JOINT

- ❑ ❑ Arthritis
- ❑ ❑ Hernia
- ❑ ❑ Low back pain
- ❑ ❑ Neck pain or stiffness
- ❑ ❑ Pain between shoulders
- ❑ ❑ Poor posture
- ❑ ❑ Sciatica

Pain or numbness in:

- ❑ ❑ Shoulders ❑ L ❑ R
- ❑ ❑ Arms ❑ L ❑ R
- ❑ ❑ Elbows ❑ L ❑ R
- ❑ ❑ Hands ❑ L ❑ R
- ❑ ❑ Hips ❑ L ❑ R
- ❑ ❑ Legs ❑ L ❑ R
- ❑ ❑ Knees ❑ L ❑ R
- ❑ ❑ Feet ❑ L ❑ R
- ❑ ❑ Tail bone

EYES, EARS, NOSE & THROAT

NOW PAST

- ❑ ❑ Asthma
- ❑ ❑ Deafness
- ❑ ❑ Earache
- ❑ ❑ Ear discharge
- ❑ ❑ Ear noises
- ❑ ❑ Enlarged glands
- ❑ ❑ Enlarged thyroid
- ❑ ❑ Eye pain
- ❑ ❑ Failing vision
- ❑ ❑ Far sightedness
- ❑ ❑ Gum trouble
- ❑ ❑ Hay fever
- ❑ ❑ Hoarseness
- ❑ ❑ Nasal obstruction
- ❑ ❑ Near sightedness
- ❑ ❑ Nosebleeds
- ❑ ❑ Sinus infection
- ❑ ❑ Sore throat
- ❑ ❑ Tonsillitis

CARDIOVASCULAR

- ❑ ❑ Hardening of the arteries
- ❑ ❑ High blood pressure
- ❑ ❑ Low blood pressure
- ❑ ❑ Pain over heart
- ❑ ❑ Poor circulation
- ❑ ❑ Rapid heart beat
- ❑ ❑ Slow heart beat
- ❑ ❑ Swelling of ankles

RESPIRATORY

NOW PAST

- ❑ ❑ Chest pain
- ❑ ❑ Chronic cough
- ❑ ❑ Difficult breathing
- ❑ ❑ Spitting up blood
- ❑ ❑ Spitting up phlegm
- ❑ ❑ Wheezing

SKIN

- ❑ ❑ Boils
- ❑ ❑ Bruise easily
- ❑ ❑ Hives or allergy
- ❑ ❑ Itching
- ❑ ❑ Skin eruptions (rash)
- ❑ ❑ Varicose veins

GENITOURINARY

- ❑ ❑ Blood in urine
- ❑ ❑ Frequent urination
- ❑ ❑ Kidney infection or stones
- ❑ ❑ Painful urination
- ❑ ❑ Pus in urine

FOR WOMEN ONLY

- ❑ ❑ Congested breasts
- ❑ ❑ Excessive menstrual flow
- ❑ ❑ Hot flashes
- ❑ ❑ Irregular cycle
- ❑ ❑ Menopausal symptoms
- ❑ ❑ Painful menstruation
- ❑ ❑ Vaginal discharge
- ❑ ❑ Yeast infections

❑ Yes ❑ No **Are you pregnant?**

Date of last period: _____

FAMILY HISTORY

The following members have a same or similar problem as I do:

❑ Father ❑ Mother ❑ Brother ❑ Sister ❑ Spouse ❑ Child

Have you been tested for HIV? ❑ No ❑ Yes If yes, are you: ❑ Negative ❑ Positive

Do you have hepatitis? ❑ No ❑ Yes: Type ____

CHECK THE FOLLOWING CONDITION(S) YOU HAVE HAD:

❑ AIDS/HIV	❑ Constipation	❑ Gout	❑ Multiple sclerosis	❑ Scarlet fever
❑ Alcoholism	❑ Depression	❑ Headaches	❑ Mumps	❑ Shingles
❑ Allergies	❑ Diabetes	❑ Heart disease	❑ Osteoporosis	❑ Stroke
❑ Anemia	❑ Digestion problems	❑ Herniated disk	❑ Parkinson's	❑ Thyroid issues
❑ Appendicitis	❑ Diphtheria	❑ Influenza	❑ Pleurisy	❑ TMJ
❑ Arteriosclerosis	❑ Ear ringing	❑ Insomnia	❑ Pneumonia	❑ Tuberculosis
❑ Arthritis	❑ Eczema	❑ Lumbago	❑ Polio	❑ Typhoid fever
❑ Bladder problems	❑ Emphysema	❑ Malaria	❑ Poor circulation	❑ Ulcers
❑ Cancer	❑ Epilepsy	❑ Measles	❑ Prostate issues	❑ Venereal disease
❑ Chronic fatigue	❑ Fever blisters	❑ Migraine	❑ Rheumatoid arthritis	❑ Vertigo/dizziness
❑ Cold sores	❑ Goiter	❑ Miscarriage	❑ Rheumatic fever	❑ Whooping cough

STRESSORS

- ❑ Alcohol Drinks/Week _____
- ❑ Coffee/Caffeine Drinks Cups/Day _____
- ❑ High stress level Reason _____
- ❑ Smoking Packs/Day _____

EXERCISE

- ❑ None
- ❑ Moderate
- ❑ Daily
- ❑ Heavy

Do you wear a heel lift? ❑ Yes ❑ No Do you use a cervical (neck) pillow? ❑ Yes ❑ No

Dental visits: ❑ Every 6 months ❑ Yearly ❑ Toothache or emergency only ❑ None ❑ Dentures

On a scale of 1-10 (ten is the highest commitment), how committed are you to resolving this complaint?___

Have your symptoms affected your quality of life? ❑ Yes ❑ No
Explain: _____
_____

What are your goals with spinal care? ❑ Relief ❑ Corrective ❑ Wellness ❑ Other: _____
_____

Are you interested in preventative care after your symptoms resolve? ❑ Yes ❑ No

Insurance verification and authorization is not a guarantee of payment. I understand that I may be responsible for any balance that is not paid by my insurance. Payment in full for all services rendered and products received is due at the end of each visit.

We value and protect your privacy. I authorize Lenz Chiropractic, PC to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions. I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed.

_____ _____
Patient Signature Date

_____
Signature of Parent/Guardian (if patient is under 18)

Thank You!