ORR CHIROPRACTIC / STOW CHIROPRACTIC HEALTH CENTER, DR. DOUGLAS ORR, D.C.

NEW PATIENT FORM

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name: First: Middle:			Marital Status: Single / Mar / Div / Sep / Wid
Home phone no.: ( )	Cell phone no.: ( )	Birth date: / /	Age:	Sex: ❑ M ❑ F
Email:	Is this your first visit at a chiropractor?		
Street address:	City:	State:	ZIP Code:
Occupation:	Employer:	Employer phone no.: ( )	

Are you here today for any of the following (please check the box that applies):

❑ Work related injury ❑Auto accident ❑Other

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other _____

How may we contact you for upcoming appointments (Please mark all that apply): ❑ Text ❑ Email ❑ Phone

INSURANCE INFORMATION (FILL OUT ONLY IF INSURANCE CARD CANNOT BE COPIED)

Primary Insurance (or N/A)	Subscriber's name:	Group No.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Secondary insurance (or N/A):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of Emergency Contact	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

AUTHORIZATION

I authorize Stow Chiropractic Health Center (Orr Chiropractic) to furnish information to my insurance company for prior authorization, pre-certification or payment of health care services. This information may include, but is not limited to claims, copies of medical information, faxes and phone calls concerning care provided or proposed. I shall assign all payments for these services to this practice. I also understand that I am responsible for co-payments, amounts applied toward my deductible or any other amount due that is required by my insurance carrier by contract or state regulations. I also agree to pay in full payments that are not covered by my insurance carrier that is rendered unto me. I also give my authorization for chiropractic services or any care given directly to me. I understand all risks/benefits associated with treatment although risks of chiropractic are statistically low they may include worsening of condition, fracture, herniated disc, stroke, compression of nerves. Benefits include increase range of motion and decrease in pain/symptoms. I have reviewed the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

_____ _____

Patient signature (Or parent/ guardian if under 18yrs old) *Date*

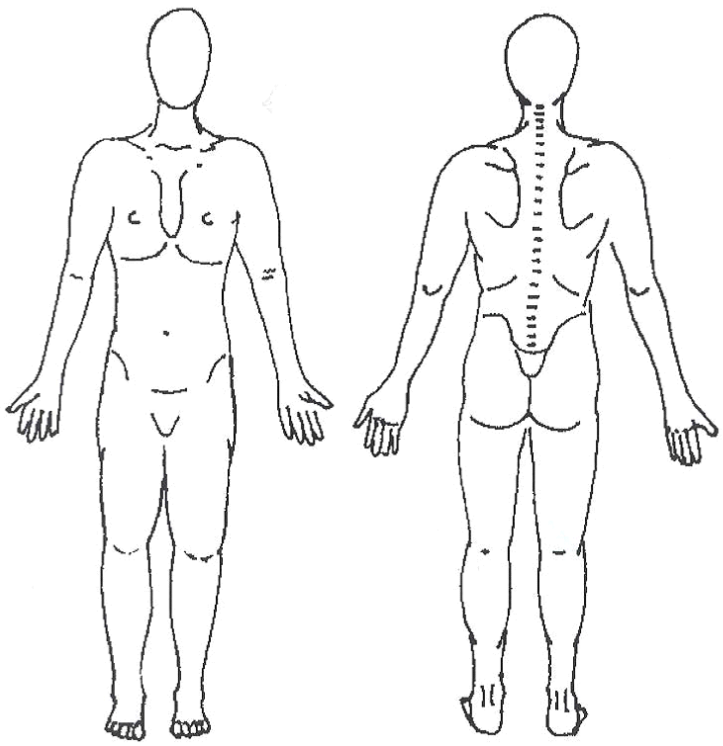
(CONTINUE ON BACK)

MEDICAL HISTORY			
Height	Weight	Are you currently pregnant? ❑ Yes ❑ No ❑ N/A	Alcohol Consumption ❑ Never ❑ Social ❑ Moderate ❑ Heavy
Smoking History ❑ Never ❑ In the past, but not currently ❑ Currently		High blood pressure ❑ Yes ❑ No	Medications (please list):
Past Surgeries (approximate dates):			
Fractures:		Allergies:	
Have you seen a chiropractor in the past? ❑ Yes ❑ No	If you've seen a chiropractor, how long ago and what for condition/s:		
Any other information we should know about health history?			
Family physician:		Family physician phone:	

Key: Pins and Needles = 000000 Stabbing = / / / / / /
Burning = xxxxxx Deep Ache = zzzzzz

Please use the key at the right to indicate where you are feeling the pain and the type of pain.

For example if feeling burning in the right arm put xxxx on the right arm.



Please briefly describe what brings you in today:

Please circle your current level of pain for each condition that affects you.

	No Pain										Worst Pain
	0	1	2	3	4	5	6	7	8	9	10
Headache	0	1	2	3	4	5	6	7	8	9	10
Neck Pain	0	1	2	3	4	5	6	7	8	9	10
Low Back Pain	0	1	2	3	4	5	6	7	8	9	10
Numbness/Tingling	0	1	2	3	4	5	6	7	8	9	10
Other (_____)	0	1	2	3	4	5	6	7	8	9	10

Characteristics of your pain

	How **often** does your pain occur (Circle one)	How **long** does your pain typically last (Circle one)	Rate your pain when your pain is at its worst (1 being mild and 10 being worst)
Headache	Constant Once a day Once a week Once a month Once a year	Constant Couple hours 1 hour 30 minutes 1 minute	1 2 3 4 5 6 7 8 9 10
Neck Pain	Constant Once a day Once a week Once a month Once a year	Constant Couple hours 1 hour 30 minutes 1 minute	1 2 3 4 5 6 7 8 9 10
Low Back Pain	Constant Once a day Once a week Once a month Once a year	Constant Couple hours 1 hour 30 minutes 1 minute	1 2 3 4 5 6 7 8 9 10
Numbness/Tingling	Constant Once a day Once a week Once a month Once a year	Constant Couple hours 1 hour 30 minutes 1 minute	1 2 3 4 5 6 7 8 9 10
Other (_____)	Constant Once a day Once a week Once a month Once a year	Constant Couple hours 1 hour 30 minutes 1 minute	1 2 3 4 5 6 7 8 9 10

Please circle who is affected by this condition (**Y** yourself), (**F** father), (**M** mother), (**B** brother), (**S** sister)

Arthritis	Y F M B S	Epilepsy	Y F M B S	Neuritis	Y F M B S
Asthma/hay fever	Y F M B S	Headaches	Y F M B S	Neuralgia	Y F M B S
Back Pain	Y F M B S	Heart Trouble	Y F M B S	Pinched Nerves	Y F M B S
Bursitis	Y F M B S	High Blood Pressure	Y F M B S	Scoliosis	Y F M B S
Cancer	Y F M B S	Insomnia	Y F M B S	Sinus Trouble	Y F M B S
Constipation	Y F M B S	Kidney Trouble	Y F M B S	Stomach Trouble	Y F M B S
Diabetes	Y F M B S	Liver Trouble	Y F M B S	Other (_____)	Y F M B S
Herniated Disc	Y F M B S	Migraines	Y F M B S		
Emphysema	Y F M B S	Nervousness	Y F M B S		