

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | | |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | INTAKE |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Smallpox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Coffee |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tea |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Cigarettes |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago | <input type="checkbox"/> White Sugar |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema | |

CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD:

MUSCULOSKELETAL

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficulty Chewing/Clicking Jaw
- General Stiffness

NERVOUS SYSTEM

- Nervousness
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

GENERAL

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

GASTROINTESTINAL

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea

- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

GENITO-URINARY

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

C-V-R

- Chest Pain
- Short Breath
- Blood Pressure Program
- Irregular Heartbeat
- Heart Program
- Lung Program/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

EENT

- Vision Programs
- Dental Programs
- Sore Throat
- Earaches
- Hearing Difficulty
- Stuffed Nose

FEMALES ONLY:

Date of last period:

Are you pregnant?

- Yes No

MALE/FEMALE

- Menstrual Irregularity
- Intense Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate Sexual Dysfunction
- Other Problems:

FAMILY HISTORY

The following members have the same or similar problem(s) as I do:

- Mother
- Father
- Brother
- Sister
- Spouse
- Child

NEW PATIENT INFORMATION

Name:		Date:	
Address:		City/state/zip:	
Home Phone:		Alternate Phone Number:	
Birth date:	Age:	Height:	Weight:
Marital Status:		Email:	SS#:
Your Employer:		Occupation:	
Spouse's Name:		Spouse's Employer:	
Emergency Contact:		Phone #:	
Name of Insurance Co.:			
Name of Insured:		Policy #:	
Date of Birth:		Insured's SS#:	

Current Health complaints/reasons for consulting our office:

Who may we thank for referring you? _____

Have you had same or similar problems before? _____

If so, for how long? _____

Is this the result of an auto or work injury? _____ If so, when? _____

Have you ever been seen by a chiropractor before? _____

Surgeries you have had: _____

Medications you currently take: _____

Is there any chance you are pregnant: _____

I, the undersigned (or my dependent) assign directly to Calvert Chiropractic (Josh Ellenbogen, D.C.) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. After reading and filling out this form, I verify that all the information I have given is accurate.

Patient or Guardian Signature: _____ Date: _____