

JACOBSON CHIROPRACTIC PLLC
1715 N 7th St Phoenix AZ 85006
602-258-3100

New Patient Registration

Name: _____ Age: _____ Date of birth: _____ Date: _____
 LAST FIRST MIDDLE

Address: _____ Social Security #: _____ Male Female

City, State, Zip: _____ Marital Status: M S W D # of Children _____

Home Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____) _____ Email address: _____

Employer: _____ Occupation: _____

Spouse: _____ Spouse's Employer: _____

In case of emergency, notify _____ **Relationship:** _____ **Phone (_____)** _____

Current Symptoms: 1. _____ 2. _____ 3. _____ 4. _____

When did your symptoms begin? _____

In general what makes your symptoms better? _____

In general what makes your symptoms worse? _____

In general how would you describe your pain? (ache, burn, dull, sharp, throbbing): _____

Are your symptoms local or do they travel to another area? (If they travel, to where?) _____

Are symptoms: Constant >76% Frequent 51-75% Occasional 26-50% Intermittent <25% **of your waking hours**

<u>Please list all medications and dosage:</u>	<u>Frequency</u>	<u>For What Illness?</u>

List any allergies to medications, foods or other: _____

Are you pregnant? Yes No First day of last menstrual cycle: _____

Do you smoke? Yes No; How much? _____ Do you drink alcohol? Yes No; How much? _____

<u>Please list all serious illnesses and serious accidents:</u>	<u>Month and Year</u>	<u>City, State</u>

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Patient's Name: _____ Date: _____

<u>Please list any recent x-rays, lab or other tests:</u>	<u>Date</u>	<u>Facility/Doctor</u>

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?:

- | | | | |
|---|--|--|---|
| Tuberculosis <input type="checkbox"/> Yes | Lung Disease <input type="checkbox"/> Yes | Gout <input type="checkbox"/> Yes | Diabetes <input type="checkbox"/> Yes |
| Kidney Disease <input type="checkbox"/> Yes | Stomach/Ulcer <input type="checkbox"/> Yes | Heart Disease <input type="checkbox"/> Yes | Hepatitis <input type="checkbox"/> Yes |
| Sciatica <input type="checkbox"/> Yes | Blood Pressure <input type="checkbox"/> Yes | Transfusion <input type="checkbox"/> Yes | Polio / MS <input type="checkbox"/> Yes |
| Colon Disease <input type="checkbox"/> Yes | Stroke <input type="checkbox"/> Yes | Cancer <input type="checkbox"/> Yes | Bleeding <input type="checkbox"/> Yes |
| Paralysis <input type="checkbox"/> Yes | Seizures <input type="checkbox"/> Yes | Arthritis <input type="checkbox"/> Yes | Asthma <input type="checkbox"/> Yes |
| Anemia <input type="checkbox"/> Yes | Thyroid Disease <input type="checkbox"/> Yes | Drug Dependence <input type="checkbox"/> Yes | AIDS <input type="checkbox"/> Yes |

PLEASE PROVIDE US WITH THE APPROPRIATE INSURANCE INFORMATION:

YOUR HEALTH INSURANCE COMPANY: _____

Address: _____ Insured: _____

Date of Birth: _____ Policy #: _____ Group #: _____

Telephone: (_____) _____

HIPAA Compliance

Our office is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

Patient Signature: _____ Date: _____