Triangle Spine Center's New Patient Paperwork

Date _____

First Name _____ Middle Initial ____ Last Name _____

Address Line 1 _____

Address Line 2 _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____-_____ **Work Phone (_____) _____-_____**

Cell Phone (_____) _____-_____ **Email _____**

Date of Birth _____/_____/_____ **Sex:** □ Male □ Female

Social Security Number: _____-_____-_____ **Marital Status:** □ Single □ Married □ Other

Employment Status: □ Employed □ Unemployed □ FT Student □ PT Student □ Other_____

Emergency Contact

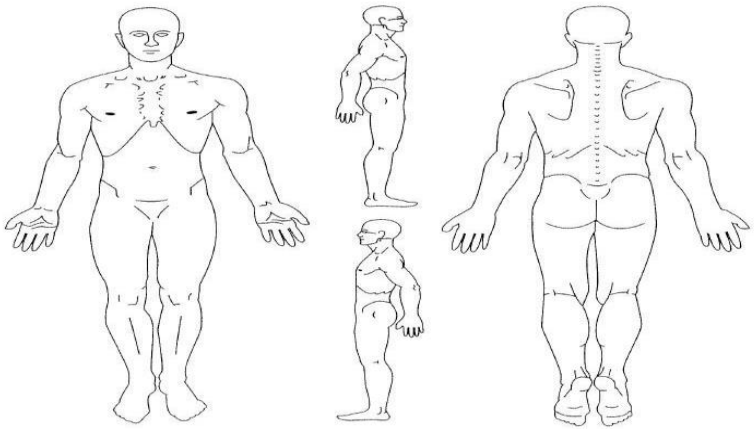
Contact Name _____ **Relationship to Patient _____**

Contact Home Phone (_____) _____-_____ **Cell Phone (_____) _____-_____**

How did you hear about our office? _____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache



Describe your symptoms in order of severity, with worse symptom being #1: _____

_____

_____

_____

How did your symptoms begin? _____

_____

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day) □ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Medical Conditions: _____

Surgeries: _____

Allergies: _____

Social History: (Check all that apply to you)

Caffeine use:	□ occasional	□ often	□ never
Drink Alcohol:	□ occasional	□ often	□ never
Exercise:	□ occasional	□ often	□ never
Cigarettes:	□<1 pack/day	□ >1 pack/day	□ never

Other _____

Family History:

Parent_____ Sibling _____

Parent _____ Sibling _____

Please list all current medications being taken _____

_____

_____

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____

Patient's Signature _____ Date_____

Consent to Treat a Minor: (Minor's Printed Name) _____

Guardian / Spouse's Signature Authorizing Care _____

Patient's Signature _____ Date_____