New Patient Information

Name: _____Date:_____

Address: _____City:_____

State:_____ Zip:_____ SS# _____ Sex: M/ F

Height: _____ Weight:_____ Marital Status M / S / D / W

Date of Birth ___/___/___ Phone#:(____)_____ E-Mail: _____

Occupation: _____Employer:_____

Primary Care Physician _____Tele # _____

Health Insurance _____ ID#:_____

Insured's Name: _____ D.O.B. _____ Relationship: _____

How did you hear of Lois Chiropractic ? _____

1. Describe your current complaint

_____

_____

2. When did this begin? And what caused it? _____

_____

3. How would you describe the pain?

☐ **Sharp** ☐ **Soreness** ☐ **Throbbing** ☐ **Tingling** ☐ **Dull** ☐ **Stiffness**
☐ **Spasm** ☐ **Burning** ☐ **Ache** ☐ **Weakness** ☐ **Numbness** ☐ **Shooting**

4. Are you currently taking any medication? ☐ **Yes** ☐ **No**
If yes, please list _____

_____

Please turn over and complete other side ☺

5. Please List any other health problems you may have and surgeries: _____

_____

6. Please list names of any other Dr. that you have treated with for this condition

_____

	Past	Present		Past	Present
Neck Pain	☐	☐	Shoulder Pain	☐	☐
Arm/Elbow Pain	☐	☐	Upper Back Pain	☐	☐
Lower Back Pain	☐	☐	Leg Pain	☐	☐
Dizziness	☐	☐	Headaches	☐	☐
Jaw Pain	☐	☐	Mid Back Pain	☐	☐

Doctors notes

AUTHORIZATION FOR PAYMENT

I _____ authorize payment for services to go directly to Robert A. Lois, D.C. at Lois Chiropractic Office (768 East Main Street, Shrub Oak, NY 10588)

_____ _____

Patient Signature Date