NEW PATIENT HEALTH FORM

MADISON UPPER CERVICAL CENTER

Dr. Valeri Briski
NUCCA Chiropractor

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Date _____

Name _____

Address _____ Apt # _____

City _____ State _____ Zip Code _____

E-Mail _____ Referred By _____

Cell Phone _____ Home Phone _____

Work Phone _____ Age _____ Birthdate _____

Marital Status (circle one): Married Single Widowed Separated Divorced Cohabitating

Number of Children and Ages _____

Occupation (if dependent, list parent's occupation) _____

Employer _____

Address _____ Phone _____

City _____ State _____ Zip Code _____

Spouse's Name _____ Occupation _____

Employer _____ Phone _____

Emergency Contact _____ Phone _____

I will be paying by: Cash Check Mastercard/Visa

Person Responsible for payment _____

Relation _____ Phone _____

Purpose for this appointment _____

Other doctors seen for this condition _____

Have you been treated for any health condition by a physician in the last year? Yes No

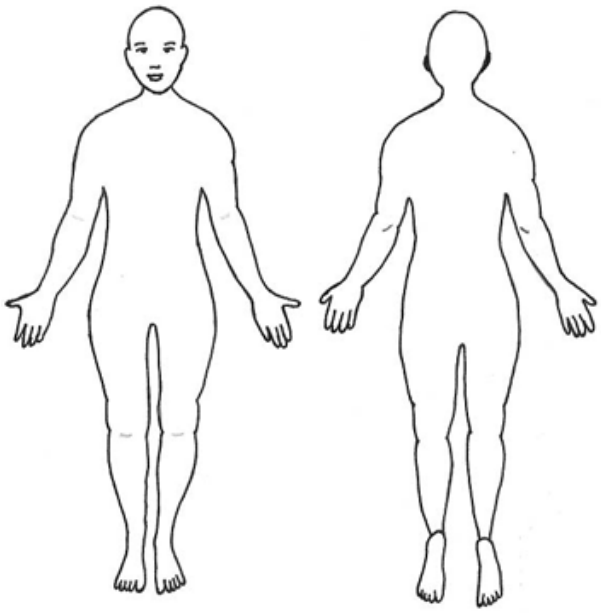
Describe _____

_____

_____

Current medications and supplements _____

_____



Please outline the area of discomfort on the diagram.

Current health problems _____

_____

_____

_____

_____

_____

_____

Please circle any of the following that apply to your current/past medical history:

Allergy	Prostate problems	Thyroid problems	Emphysema
Asthma	Swollen joints	Diabetes	Low blood pressure
Shoulder pain	Belching or gas	Enlarged glands	Poor appetite
Heartburn	Fainting	Gout	Surgery
Hay fever	Colon problems	Nasal congestion	Weakness in arms
Hiatal hernia	Headaches	Itching	Slow heart beat
Migraines	Nosebleeds	Chronic cough	Bad posture
Sore throats	Tuberculosis	Heart disease	Anemia
Loss of weight	Difficulty breathing	Hemorrhoids	Poor hearing
Shortness of breath	Jaundice	Cancer	Burning sensations
Hardening of arteries	Polio	Arthritis	Fatigue
Liver problems	Bursitis	Chest pain	Eczema/Hives
Hyperactivity	Poor circulation	Vomiting	Constipation
Numbness in legs or feet	Sprained ankle	Broken bones	Loss of sleep
Stroke	Vomiting of blood	Weakness in legs	Excessive hunger
Swollen ankles	Bed-wetting	Rheumatic fever	Nervousness
Stomach ulcers	Low back pain	Sinus infection	Tumor
Foot problems	Tailbone pain	Convulsions	Numbness in arms/hands
Frequent urination	Sciatica	Stomach aches	Rapid heart beat
Kidney stone	Scoliosis	Dentures	Difficulty swallowing
Kidney infection	Neck pain or stiffness	Bruise easily	Heart attack
Bladder infection	Leg pain	Diarrhea	Ringing in ears
Painful Urination	Pain between shoulders	Varicose veins	Angina
Poor urine control	Arm pain	Gallbladder problems	Vision disturbances
Blood in urine	Knee pain	Depression	

For Women Only:

Premenstrual tension	Tubal ligation	Menstrual cramps	Irregular cycle
Menopausal symptoms	Vaginal discharge	Hysterectomy	
Excessive flow	Fertility problems	Lumps in breast	

Is there any possibility that you may be pregnant? _____ Date of last menstrual period _____

Exercise Frequency

None ____
Infrequent ____
____ times/week
Daily____

Work Activity

Sitting ____
Standing ____
Light labor ____
Heavy labor ____

Habits

Smoking ____ packs/day
Alcohol ____ drinks/day
Coffee/caffeine ____ cups/day
Stress (reason) _____

_____

_____

Exercise Intensity

Light ____
Moderate ____
Intense ____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment at the time services are rendered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____

Parent/Guardian Signature (if a minor) _____ Date _____

Privacy Notice:

This office is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to the use of your name.

By way of signing this form, I release this office from all liability and authorize the use of my last name for the purpose of greeting me, announcing me into a room or around the office in the presence of others.

Print Name _____

Patient's Signature _____

Parent/Guardian Signature _____