Symmetry Health
4432 Ingraham Street
San Diego, Ca 92109
Phone: (858) 270-2225 Fax: (858) 270-6898
www.SymmetryHealthChiro.com

NEW PATIENT REGISTRATION
DR. MICHAEL WILSON

Name: _____ Today's Date: _____
Last First Middle

Mailing Address_____
Street City State Zip

Social Security # _____ – _____ – _____ Date of Birth _____/_____/_____

Home Phone # (_____) _____–_____** Work Phone # (_____) _____–_____**

Cell Phone # (_____) _____–_____** E-mail Address: _____**

Emergency Contact_____ Relationship_____ Phone# (_____)_____–_____

Employer_____ Occupation_____ Phone# (_____)_____–_____

Is this visit routine/accident/illness/other: _____ If Accident (date) _____

Name of Insurance_____ ID#_____Grp#_____

RESPONSIBLE PARTY INFORMATION

Name (Guarantor)_____
Last First Middle

Relationship to Patient _____ Phone# (_____)_____–_____

Address _____
Street City State Zip

Employer_____

Address_____ Phone #(_____)_____–_____

Please notify our front office staff if there is an alternate address / phone number or form of communication that you wish us to contact you by other than your listed information above.

I have read and understand that this alternative is available to me:

_____
Signature Date

CHIROPRACTIC NEW PATIENT INTAKE

Patient's Name _____ **DOB** _____ **Date:** _____

Last *First* *Middle initial*

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment. Please check the degree of all conditions you currently have or have had. To be responsible for your case, we need your complete health history.

O = Occasional F = Frequent C = Constant

O F C

Muscle / Joint
- ☐ ☐ ☐ Arthritis
- ☐ ☐ ☐ Bursitis
- ☐ ☐ ☐ Foot trouble
- ☐ ☐ ☐ Hernia
- ☐ ☐ ☐ Low back pain
- ☐ ☐ ☐ Lumbago
- ☐ ☐ ☐ Neck pain, stiffness
- ☐ ☐ ☐ Pain between shoulders

General
- ☐ ☐ ☐ Allergy
- ☐ ☐ ☐ Chills
- ☐ ☐ ☐ Convulsions
- ☐ ☐ ☐ Dizziness
- ☐ ☐ ☐ Fainting
- ☐ ☐ ☐ Fatigue
- ☐ ☐ ☐ Fever
- ☐ ☐ ☐ Headache
- ☐ ☐ ☐ Loss of sleep
- ☐ ☐ ☐ Loss of weight
- ☐ ☐ ☐ Nervousness, depression
- ☐ ☐ ☐ Neuralgia
- ☐ ☐ ☐ Numbness
- ☐ ☐ ☐ Sweats
- ☐ ☐ ☐ Tremors

Cardiovascular
- ☐ ☐ ☐ Hardening of arteries
- ☐ ☐ ☐ High blood pressure
- ☐ ☐ ☐ Low blood pressure
- ☐ ☐ ☐ Pain over heart
- ☐ ☐ ☐ Poor circulation
- ☐ ☐ ☐ Rapid heartbeat
- ☐ ☐ ☐ Slow heartbeat
- ☐ ☐ ☐ Swelling of ankles

Genitourinary
- ☐ ☐ ☐ Bed-wetting
- ☐ ☐ ☐ Blood in urine
- ☐ ☐ ☐ Frequent urination
- ☐ ☐ ☐ Lack of kidney control
- ☐ ☐ ☐ Kidney infection
- ☐ ☐ ☐ Painful urination
- ☐ ☐ ☐ Prostate trouble
- ☐ ☐ ☐ Pus in urine

O F C

Eye, Ear, Nose and Throat
- ☐ ☐ ☐ Asthma
- ☐ ☐ ☐ Colds
- ☐ ☐ ☐ Crossed eyes
- ☐ ☐ ☐ Deafness
- ☐ ☐ ☐ Dental decay
- ☐ ☐ ☐ Earache
- ☐ ☐ ☐ Ear discharge
- ☐ ☐ ☐ Ear noise
- ☐ ☐ ☐ Enlarged glands
- ☐ ☐ ☐ Enlarged thyroid
- ☐ ☐ ☐ Eye pain
- ☐ ☐ ☐ Failing vision
- ☐ ☐ ☐ Far sightedness
- ☐ ☐ ☐ Gum trouble
- ☐ ☐ ☐ Hay fever
- ☐ ☐ ☐ Hoarseness
- ☐ ☐ ☐ Nasal obstruction
- ☐ ☐ ☐ Near sightedness
- ☐ ☐ ☐ Nose bleeds
- ☐ ☐ ☐ Sinus infection
- ☐ ☐ ☐ Sore throat
- ☐ ☐ ☐ Tonsillitis

Gastrointestinal
- ☐ ☐ ☐ Belching or gas
- ☐ ☐ ☐ Colitis
- ☐ ☐ ☐ Colon trouble
- ☐ ☐ ☐ Constipation
- ☐ ☐ ☐ Diarrhea
- ☐ ☐ ☐ Difficult digestion
- ☐ ☐ ☐ Bloated abdomen
- ☐ ☐ ☐ Excessive hunger
- ☐ ☐ ☐ Gallbladder trouble
- ☐ ☐ ☐ Hemorrhoids
- ☐ ☐ ☐ Intestinal worms
- ☐ ☐ ☐ Jaundice
- ☐ ☐ ☐ Liver trouble
- ☐ ☐ ☐ Nausea
- ☐ ☐ ☐ Pain over stomach
- ☐ ☐ ☐ Poor appetite
- ☐ ☐ ☐ Vomiting
- ☐ ☐ ☐ Vomiting of blood

O F C

Skin
- ☐ ☐ ☐ Boils
- ☐ ☐ ☐ Bruise easily
- ☐ ☐ ☐ Dryness
- ☐ ☐ ☐ Hives or allergy
- ☐ ☐ ☐ Itching
- ☐ ☐ ☐ Skin eruptions (rash)
- ☐ ☐ ☐ Varicose veins

Pain or numbness in
- ☐ ☐ ☐ Shoulders
- ☐ ☐ ☐ Arms
- ☐ ☐ ☐ Elbows
- ☐ ☐ ☐ Hand
- ☐ ☐ ☐ Hips
- ☐ ☐ ☐ Legs
- ☐ ☐ ☐ Knees
- ☐ ☐ ☐ Feet
- ☐ ☐ ☐ Painful tailbone
- ☐ ☐ ☐ Poor posture
- ☐ ☐ ☐ Sciatica
- ☐ ☐ ☐ Spinal curvature
- ☐ ☐ ☐ Swollen joints

Respiratory
- ☐ ☐ ☐ Chest pain
- ☐ ☐ ☐ Chronic cough
- ☐ ☐ ☐ Difficult breathing
- ☐ ☐ ☐ Spitting up blood
- ☐ ☐ ☐ Spitting up phlegm
- ☐ ☐ ☐ Wheezing

Women only
- ☐ ☐ ☐ Congested breasts
- ☐ ☐ ☐ Cramps or backache
- ☐ ☐ ☐ Excess menstrual flow
- ☐ ☐ ☐ Hot flashes
- ☐ ☐ ☐ Irregular cycle
- ☐ ☐ ☐ Lumps in breast
- ☐ ☐ ☐ Menopause
- ☐ ☐ ☐ Painful menstruation
- ☐ ☐ ☐ Vaginal discharge

Are you pregnant? ☐Yes ☐No
If yes, how many months?____
How many children do you have?____

Check any of the following conditions you currently have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cholera
- ☐ Cold sores
- ☐ Diabetes
- ☐ Diptheria
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Herpes
- ☐ Influenza
- ☐ Lumbago
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Whooping cough

Describe chiropractic problem: _____

_____

How long have you had this condition? Is it getting worse? ☐ Yes ☐ No

Does it bother your (check appropriate box): ☐ Work ☐ Sleep ☐ Other (please specify)

What seemed to be the initial cause?

Have you seen a chiropractor before? ☐ Yes ☐ No If yes, how long ago? _____
For what reason?

Are you under the care of a physician? ☐ Yes ☐ No If yes, for what reason?

Patient's Name _____ **DOB** _____ **Date** _____

Have you been hospitalized in the last 5 years? ☐ Yes ☐ No If yes, for major surgery? ☐ Yes ☐ No for serious injury? ☐ Yes ☐ No
Have you had any mental or emotional disorders? ☐ Yes ☐ No If yes, when?
Indicate the drugs do you now take? ☐ Birth control pills ☐ Tranquilizers ☐ Pain Killers ☐ Other (specify)
Do you wear: ☐ heel lifts? ☐ sole lifts? ☐ inner soles? ☐ area supports? ☐ negative heels? ☐ platform shoes?
What is the age of your mattress? Is it ☐ comfortable? ☐ uncomfortable? Do you use a bedboard? ☐ Yes ☐ No
How is most of your day spent? ☐ standing ☐ sitting ☐ walking ☐ other (specify)

Have you ever:	Yes	No	If yes, briefly explain.
- had a broken bone?	☐	☐	
- been hospitalized?	☐	☐	
- had strains or sprains?	☐	☐	
- used a cane, crutch or other support?	☐	☐	
- been struck unconscious?	☐	☐	
- been hospitalized for other than surgery?	☐	☐	
Do you:			
- take minerals, herbs or vitamins?	☐	☐	
- think you need minerals, herbs or vitamins?	☐	☐	
- have any drug allergy?	☐	☐	

When did you last have:	Never	0-6 mos.	6 -18 mos.	longer
- spinal x-ray?	☐	☐	☐	☐
- spinal examination?	☐	☐	☐	☐
- physical examination?	☐	☐	☐	☐

HABITS	None	Light	Mod	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Water	☐	☐	☐	☐
Sugar	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐

Please list any other health conditions you have been treated for, or surgery you have had in the last ten years.

_____

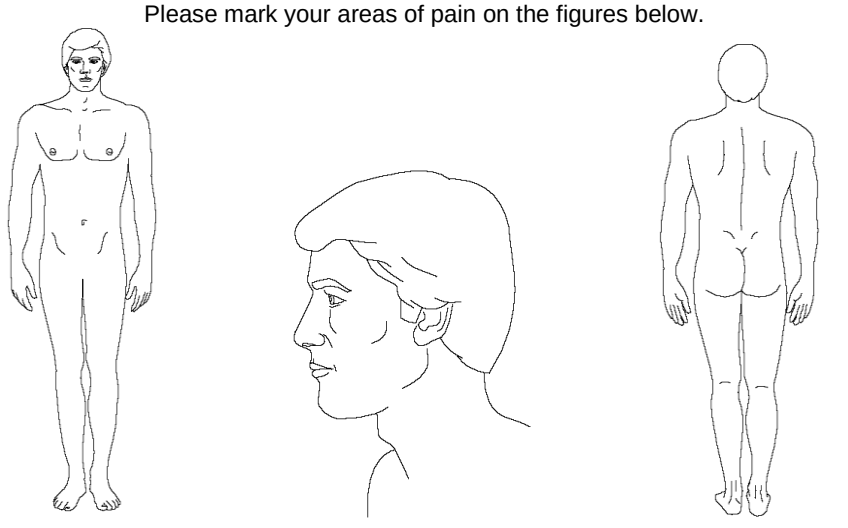
_____

_____

FAMILY HEALTH HISTORY: Information about your immediate family members, brothers, sisters, parents, and grandparents will give us a better understanding of your total health picture.

RELATIONSHIP	PRESENT AND PAST HEALTH PROBLEMS

Please mark your areas of pain on the figures below.



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HIPAA Notice of Privacy Practices and Consent

I hereby consent to the use and disclosure of my protected health information by my healthcare provider practicing out of Symmetry Health, for the purposes of treatment, payment and healthcare operations, or as otherwise required by law. Symmetry Health has posted their Notice of Privacy Practices which provides more detailed information about the usage and disclosure of my protected health information. I have a right to review the Notice prior to signing this consent and to receive a printed copy of the Notice.

I have the right to request restrictions to the usage and disclosure of my protected health information. I have the right to request an alternative to the standard method of communication of my protected health information. I have the right to revoke this consent, in writing, at any time. Revocations will be honored as of the date they are received by Symmetry Health at the following address:

4432 Ingraham Street, San Diego CA 92109

I understand that while Symmetry Health may honor these requests, they are not required by law to do so. I am aware that Symmetry Health reserves the right to change the terms of their Notice of Privacy Practices and to make new notice of Privacy Practices provisions effective for all protected health information that they maintain. In the event of amendments, Symmetry Health will make available a revised Notice of Privacy Practice for my review.

Please initial each item below.

1. _____ I hereby authorize Symmetry Health to provide Chiropractic Services for me.

2. _____ I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me at Symmetry Health.

3. _____ If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.

4. _____ I hereby assign all chiropractic benefits, including major medical benefits to which I am entitled, Medicare, private insurance and all other health plans, to Symmetry Health: chiropractic and wellness, 4432 Ingraham St, San Diego, Ca. 92109.

5. _____ I authorize release of patient's records to third parties requiring these records for determination of financial liability.

By signing this application I affirm under penalty that I have given true complete information.

I have fully read and understand the above agreements and authorizations.

Dated this _____day of _____ 20_____.

_____
Patient Signature

_____
Guarantor Signature Relationship to Patient

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AUTHORIZATION TO TREAT A MINOR

As a parent or legal guardian, I hereby authorize treatment for the following:

_____ DOB _____
Patient's full name

to any chiropractic treatment deemed advisable , if a parent or legal guardian is not available when the child is brought in for treatment.

This authorization will be effective as of _____ and expires _____.

Signature_____Witnessed by _____
(Parent or Guardian)

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New Patient Checklist

Chiropractic

- ☐ Please download and complete the **new patient intake packet** and bring to your first appointment.
- ☐ If you have not completed the new patient intake packet, please arrive 15 minutes early to fill out intake forms.
- ☐ Allow one hour for your first visit.
- ☐ **Parking is available** in the parking lot in front of Symmetry Health with additional parking available in our lot located behind the building (off of Hornblend).
- ☐ Please be courteous and **call us** if you're running late a few minutes late.
- ☐ All **payments** are due at the time of service. We accept cash, check, Visa, Mastercard, and Discover.

Please **bring** to your first appointment the following items:

- ☐ Recent blood work, x-rays and imaging, and/or medical records if necessary.
- ☐ A **list of all medications** you are currently taking (including dose, frequency, and duration).
- ☐ Insurance card or **proof of insurance**.

Thank you! We look forward to meeting you!