NEW PATIENT INFORMATION

KUPERUS
FAMILY CHIROPRACTIC

Please Print & Complete or Email Electronically Completed Form to: KuperusFrontDesk@gmail.com

Name and Nickname:

Date Of Birth: Social Security Number:

Gender At Birth: Gender Identity:

Address:

City: State: Zip:

Home: Mobile: Work:

Email:

Marital Status: Race:

Ethnicity: Preferred Language:

Occupation:

Employer:

Emergency Contact Name & Phone:

Emergency Contact Relation To Patient:

How were you referred to our office?

Primary Care Physician Name & Phone:

INSURANCE INFORMATION

Please indicate any and all insurance coverage that may be applicable in this case.

Name of Primary Insurance Company:

Name of Secondary Insurance Company:

I grant Dr. Kuperus permission to speak to my other health care providers regarding my treatment in this office. Yes No

NEW PATIENT Patient Name: Patient Account No.

Major complaints/symptoms:

Describe the pain (achy, tender, sharp, numbness, tingling):

Symptoms are worse in: morning afternoon night

Symptoms: come and go constant

Date symptoms appeared or accident happened:

Describe how the injury or symptoms first occurred:

What positions or activities aggravate your condition:

bending reaching coughing sneezing sitting standing

walking lifting lying down turning head bowel movement

What positions or activities relieve your condition:

sitting standing walking bending reaching

lifting turning head lying down

Have you been treated by a medical physician for this condition?

Have you ever had the same or a similar condition? Yes No

If yes, when and describe:

Days lost from work:

Height: Weight:

Social habits :

smoker alcohol use IV Drug use coffee tea

Date of last physical:

NEW PATIENT Patient Name: Patient Account No.

Have you ever been in any accidents, auto, fall down stairs, fall from ladder, or other significant trauma (even as a child)? When?

List all past surgeries and date:

Please list all prescription and over-the-counter medications AND supplements:

Name of medication	Dosage	Frequency	For what condition	How long have you been taking it?	Prescribing MD

Do you have medication allergies? Please list medication and reaction:

Have you gained or lost weight, without trying, in the past year?

Have you had a bacterial infection in the past 30 days?

FOR WOMEN

Is there any possibility you could be pregnant? Yes No

When was your last menstrual period?

Do you take birth control pills? Yes No

Please indicate if you have any of the following conditions:

- facial pain
- pins/needles in arms
- ringing in ears
- loss of smell
- nausea
- neck pain/stiffness
- pins/needles in legs
- depression
- loss of taste
- cold feet
- back pain/stiffness
- fatigue
- nervousness
- loss of memory
- chest pain
- arm/hand pain
- sleeping difficulties
- jaw problems
- constipation
- fainting
- headaches
- allergies
- shortness of breath
- problems swallowing
- dizziness
- blurred vision
- night pain
- bowel/bladder problems

NEW PATIENT Patient Name: Patient Account No.

FAMILY HISTORY	Self	Father	Mother	Sibling
High Blood Pressure				
Heart Problems				
Fibromyalgia				
Stroke (CVA or TIA)				
Emphysema				
Asthma				
Seizures-Convulsions				
Diabetes				
Kidney Disease				
Thyroid Disease				
Cancer				
Arthritis				
Osteoporosis				

Use the following space to list ANYTHING else you think is important and want the Doctor to know:

I verify all information provided is true and correct to the best of my ability.

Signature Date