My Favorite Chiropractor Dr. Crystal A. Mark D.C.

New Patient Profile

Please complete these pages as accurately and as completely as possible.
Bring this document with you to your next appointment.

*Today's Date:*________________________________

Name:(First MI Last) __________________________________ *Preferred Name:*______________
Gender: M / F *Height:* _____________ *Weight:* __________
SS#: _______-_______-_______ *Date of Birth:* _____/_____/______ *Marital Status:* ___________
Address: ____
City: _______________________ *State:* ____________ *Zip:* ______________
Home: _____________________ *Mobile:* __________________ *Work:* __________________
May we leave a message? Yes / No
Email: ____
Do we have permission to text or email you? Yes/ No

Employer Information

Patient's employer: _______________________________ *Occupation:* ________________________
Address: ____
City: _____________________ *State:* _______________ *Zip:* _______________
Phone Number: ___________________

Tell us a little about yourself

Your Hobbies: ____
Your Faith: ____________________________________
Do you have children: Y / N (Names and Ages): ______________________________________
How did you hear about us? Google / The Woodlands Online / Insurance Website / Other: __________
Referred By: (Name) ____

Emergency Contact Information

Name: (First MI Last) ____
Home: ______________________ *Mobile:* ____________________________
Relationship: Spouse / Parent / Child / Other: ___________________________
Primary Care Physician: ____
Physician's Phone: ___________________________

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Financial Information

☐ *Insurance* ☐ *Worker's Comp* ☐ *Self-Pay (Cash)* ☐ *Personal Injury/Auto*
☐ *Other (Please explain) :*____

Primary Insurance

Insurance Name: _________________________ *Policy #:* _______________ *Group #:* ____________
Relationship to Insured: Self / Spouse / Parent / Child / Other
Insured's Name: _______________________________________ *Gender: M / F*
Address: _________________________________ *City:* ___________ *State:* _______ *Zip:* ________
Phone: ____________________________ *Date of Birth:* ____/_____/_____
Policy Holder's SSN: _____/____/_____ *Policy Holder's Date of Birth:* ____/____/_____
Policy Holder's employer: ____

Secondary Insurance

Insurance Name: ________________________ *Policy #:*_________________ *Group #:* __________
Relationship to Insured: Self / Spouse / Parent / Child / Other
Insured's Name: _______________________________________ *Gender: M / F*
Address: ________________________________ *City:* __________ *State*_________ *Zip:* _________
Phone: ____________________________ *Date of Birth:* ____/____/____
Policy holder's SSN: _____/____/_______ *Policy Holder's Date of Birth:* ____/____/_____
Policy Holder's employer: ____

Responsible Party

Who is responsible for payment? Self / Other (Relationship) _______________________

Other than Self:

Name: (First MI Last) ____
Address: ____
City: _________________________ *State:* _________________ *Zip:* ___________
Home: ____________________________ *Mobile:* ____________________________
Email: ____

It is Usual and Customary to Pay for Service as Rendered Unless Otherwise Arranged

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Signature: ____ *Date:* ________________
Name of Guardian (if patient is a minor): ____

Health Information (confidential)

Present Health Concerns: Please list three to five of your most important health concerns, in the order of their importance to you. (For example, #1 is most important and #3 is least important). The lines in this form are self-expanding—you are welcome to enter as much information as you feel is necessary.

What is your main complaint or problem? ____
How long have you had this problem? ____
What makes it better? ____
What makes it worse? ____
What kind of test or exams have you had for it and when? ______________________________
____
What was the diagnosis? ____
What kind of medications or supplements have you tried or taken for it? __________________
____
Please elaborate if necessary: ____
____

What is your second complaint? ____
How long have you had this problem? ____
What makes it better? ____
What makes it worse? ____
What kind of tests or exams have you had for it and when? ______________________________
____
What was the diagnosis? ____
What kind of medications or supplements have you tried or taken for it? __________________
____
Please elaborate if necessary: ____
____

Medical Summary: Please write a chronological history that summarizes your medical history in regards to the above concerns. ***Example:*** *I was well until January 2015 when I had the flu. Since then, I have had daily headaches, etc.* The space in this form is self-expanding----please feel free to elaborate.

____
____
____
____
____

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____

____

WHAT YOUR MAJOR GOALS FOR THE FIRST VISIT: *What you would like to accomplish on the first visit?*

GOAL #1: ____

GOAL #2: ____

Your Questions: What questions do you have for today's visit?

____

____

____

Allergies: Please list all food, environmental, and/or drug allergies:

Type of Allergy Reaction (hives, blisters, swelling, difficulty breathing)

____

____

____

____

Current Medications: Please list the medications and/or supplements that you are currently taking, with dosages, including ***prescription medications*** (e.g., Prozac, atenolol, etc.). ***Non-prescription medications*** (e.g. Aspirin, Tylenol, ibuprofen) and/or ***health supplement*** (e.g., vitamins, minerals, herbs, supplements etc.)

NAME OF MEDICATION	DOSE OF MEDICATION (in milligrams, grams or number of capsules or tablets)	FREQUENCY OF MEDICATION (times per day/week/month)	DURATION/LEGNTH OF TIME TAKING (how long have you been taking? Days/weeks/months/years)

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Medical History: *Please list all previous medical procedures, surgeries, hospitalizations, & serious illness.*

- *Approximate date/year:*
  ____
  ____

- *Surgery/hospitalizations/procedures/serious illness/injures:*
  ____
  ____

Diet: *Do you follow any particular diet regimens or restrictions?*

EXERCISE	WALK	RUN	YOGA	OTHER	OTHER
TIMES/WEEK					
LEGNTH SPENT					

NO EXERCISE, WHAT KEEPS YOU FROM EXERCISING?	

HABITS and LIFESTYLE: *Which of the following do you use?*

HABIT	TYPE	AMOUNT	YEAR STARTED
Tobacco/Cigarettes			
Alcohol			
Caffeine (cola/soda, black tea, energy drinks coffee etc.)			
Recreational drugs			