



Parsons Chiropractic
806 S. Clinton St.
Athens, AL 35611
(256)771-7272

New Patient Forms

Welcome to Parsons Chiropractic. Filling out these new patient forms before your first visit will save time when you come in for your initial appointment, just print the forms and fill them out to the best of your ability – we've done our best to make the forms user friendly, but forms can often be intimidating.

If you have any questions, please call the office at (256)771-7272 during normal business hours (check the website for any changes in our regular operating hours).

Patient Information

Date _____ SS/HIC/Patient ID # _____

Patient Name (Last, First MI) _____

Street Address _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Patient Employer / School _____

Patient Occupation _____

Employer / School Address _____

Employer / School Phone (_____) _____

Spouse's Name _____

Spouse's Birthdate _____ Spouse's SSN _____

Spouse's Employer _____

Phone Numbers

Home Phone (_____) _____ *Please check which number you would*

Work Phone (_____) _____ *prefer us to use during the day.*

Cell Phone (_____) _____

Best time and place to reach you _____

In case of emergency, contact

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone(_____) _____

Please tell us how you were referred to the office:

Personal Referral (Name): _____

Health History

What treatment have you already received for your condition?

- Medications
 Surgery
 Physical Therapy
 Chiropractic Services
 None
 Other (Explain) _____

Name and address of other doctor(s) who have treated your condition

Date of last:

Physical Exam _____ Spinal X-Ray _____ Blood Test _____
 Spinal Exam _____ Chest X-Ray _____ Urine Test _____
 Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Are you pregnant? No Yes Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Medications	Allergies	Vitamins/Herbs/Minerals
_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
_____	_____	_____
Pharmacy Phone(_____)_____	_____	_____

Health History (Cont.)

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Aids/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prostrate Problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Herniated Disc	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chicken Pox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fractures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Other _____

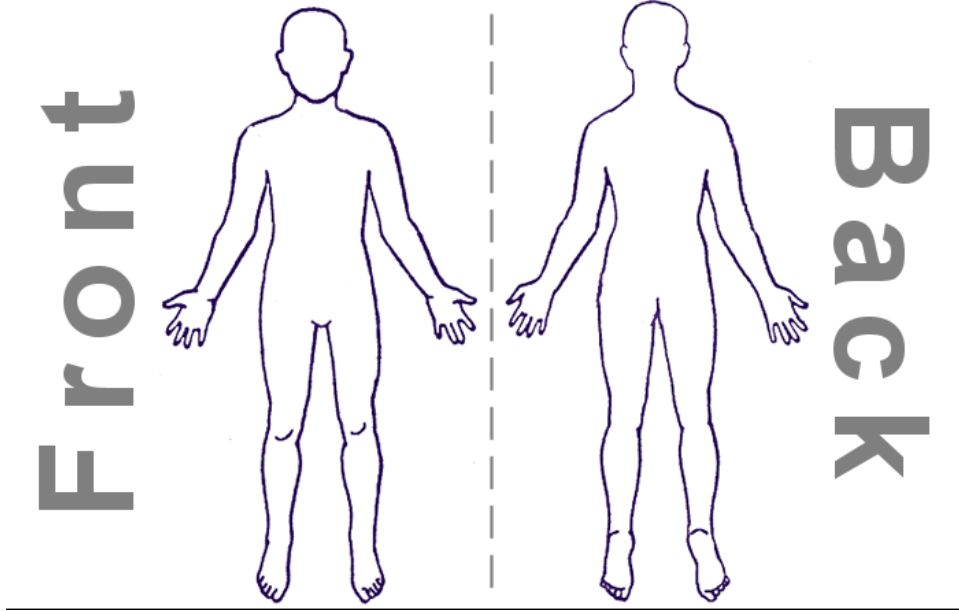
Reason for Visit

Reason for Visit _____

When did your symptoms occur? _____

Is this condition getting progressively worse? Yes No Unknown

Mark "X" on the picture where you continue to have pain, numbness, or tingling:



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform:

Sitting Standing Walking Bending Laying Down

For Office Use Only
Parsons Chiropractic

Patient Name _____
Ref# _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

(signature)

(date)

(printed name)