burden
CHIROPRACTIC & WELLNESS

111 East Avenue • Suite 203 • Norwalk, CT 06851 • T: 203.249.9886

NEW PATIENT INFORMATION

Date: ____________________

Patient Name: ____

Last First Middle

SS#: _________________________

Address: ____ City:__________________________

State: ________ Zip: _______________

Home: ___________________ Cell: ___________________ Email: __________________________

Sex: ☐ M ☐ F Age: __________ DOB: (mm/dd/yyyy) _______________________________

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor

Occupation: ____

Patient Employer/School: ____

Spouse's Name: ____

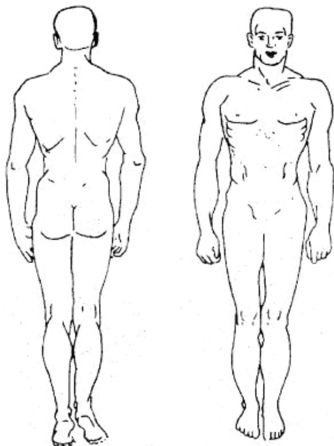
Who may we thank for referring you? ____

Reason for visit: ____

When did you first experience your symptoms: ____

Is your condition getting progressively worse? ____

Mark an X on the illustrations below where you have pain, numbness or tingling:



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

HEALTH HISTORY

What treatments have you already received for your condition? ☐ Medications ☐ Surgery
☐ Physical Therapy ☐ None ☐ Other ____

Please check the boxes below to indicate if you have had or are experiencing any of the following:

☐ Headache
☐ Neck Pain/Stiffness
☐ Jaw Pain
☐ Shoulder Pain
☐ Hand Pain
☐ Upper Back Pain
☐ Lower Back Pain
☐ Pain in Upper Leg or Hip
☐ Pain in Lower Leg or Knee
☐ Pain in Ankle or Foot
☐ Numbness in Fingers
☐ Numbness in Toes
☐ Pins and Needles in Arms
☐ Pins and Needles in Legs
☐ Joint Swelling
☐ Stiffness of Joint(s)
☐ Fainting
☐ Loss of Consciousness
☐ Dizziness
☐ Nausea
☐ Vomiting
☐ Balance Problems
☐ Coordination Problems

☐ Ringing or Buzzing in Ears
☐ Palpitations (Racing Heart)
☐ Chest Pains
☐ Shortness of Breath
☐ Loss of Appetite
☐ Night Sweats
☐ Excessive Thirst
☐ Abnormal Weight Loss
☐ Abnormal Weight Gain
☐ General Fatigue
☐ Sleep Problems
☐ Memory Problems
☐ Asthma
☐ Anorexia
☐ Anemia
☐ Nervousness
☐ Tension
☐ Anxiety
☐ Irritability
☐ Depression
☐ Cold Hands and/or Feet
☐ Fever
☐ Chronic Cough

☐ Upset Stomach
☐ Constipation
☐ Diarrhea
☐ Frequent Urination
☐ Painful Urination
☐ Abdominal Pain
☐ Difficulty Swallowing
☐ Pain Worse at Night
☐ Heartburn/Indigestion
☐ Loss of Bowel/Bladder Control
☐ Arthritis
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Diabetes
☐ Lung Problems
☐ Prostate Problem
☐ HIV/AIDS
☐ Cancer
☐ Stroke
☐ Heart Attack

Please list any medications or supplements you are currently taking:

____

INSURANCE

Primary Insurance
Insurance Company: ____
Group #: ________________________
Policy #: ________________________

Primary Insured (if other than patient)
Name: __________________________
Address: ________________________
City, ST, Zip ______________________
Employer: _______________________

Secondary Insurance (if applicable)
Insurance Company: ________________________
Group #: ___________________________________
Policy #: ___________________________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependant(s) have insurance coverage with ______________________________
Name of Insurance Company
and assign directly to Dr. Burden all insurance benefits. I understand that I am financially responsible for all charges whether or not they are paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my healthcare information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

____
Signature of Patient, Parent, Guardian or Authorized Person

____
Please print name of Patient, Parent, Guardian or Authorized Person

____
Date