Dunn Chiropractic Clinic
A Pain & Wellness Practice Since 1922

George Siegfried, D.C.
Chiropractic Physician
Since 1983
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Welcome to the Clinic!

Thank you for taking time to fill this out. It will reduce your wait at the clinic.

New Patient / Consultation Form

Filled out by:_____

Name: _____ **Date**: _____
Address: _____**City:**_____ **State**: ____Zip:_____
Cell#: _____ **Work#**: _____**Occupation**: _____
Birthdate: _____ **Age**: _____ **Email**: _____
(your email is confidential and will NOT be given out)
For appointment reminders what is your Preferred Method of Contact? Text □ Call □ Email □
Emergency Contact Name:_____ **Phone#**_____
Whom may we thank for referring you? _____
What brings you to the clinic today?
□ Chiropractic Care □ Car Accident □ Work Injury □ Nutrition Consultation
Is your visit due to a car accident? Yes □ No □ Injury date: _____
Your Insurance Carrier: _____ Claim#:_____
Have you lost any workdays? Yes □ No □ How Many? _____
What is your main pain/complaint? _____
My pain/complaint is due to?_____
My pain/complaint started:_____
How does this affect your daily life?_____
Have you ever had this pain or discomfort before? Yes □ No □
What makes your pain better and when is it better?_____
What makes your pain worse and when is worse? _____
Have you been to a chiropractor before? Yes □ No □ Who? _____
For what condition? _____When? _____
Were X-rays or MRI's Taken? Yes□ No □ When?_____**Where?**_____
Were you satisfied with your care? Yes□ No □

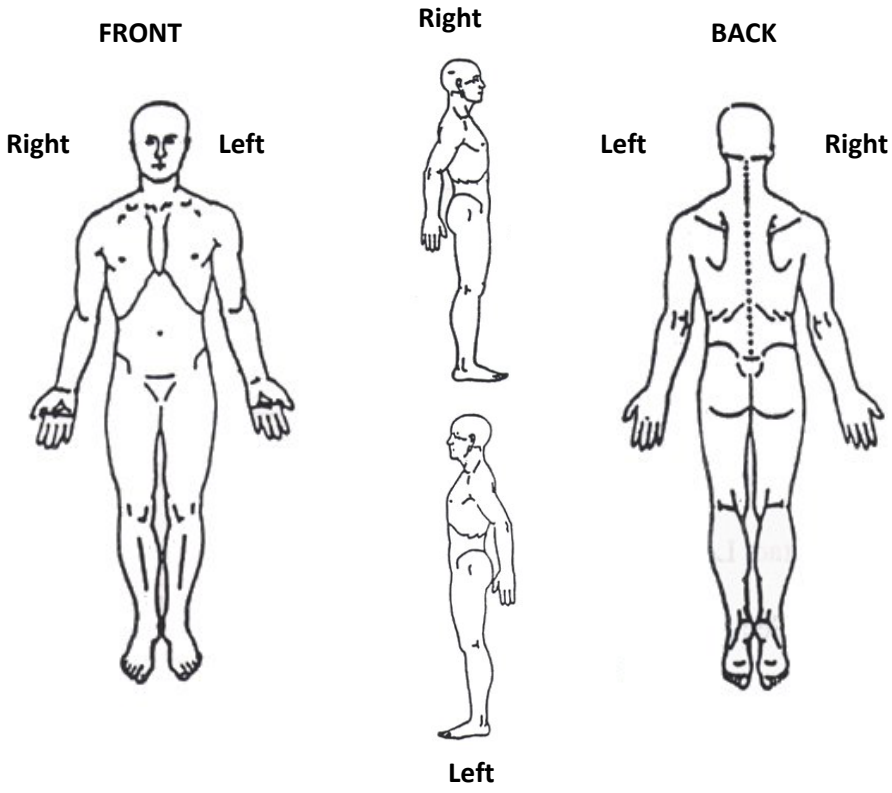
Please Go To Page 2:

What other doctors or treatment have you had for your condition?
(Medical, Naturopathic, etc.)_____
Do you have any other imaging studies done anywhere? (Xray, CT, MRI, Bone Density, etc.)
Yes □ No □ If Yes, which ones? _____
Are you taking any medications? Yes □ No □
If so for what condition(s)?_____
Are you taking any supplements/vitamins? Yes □ No □
If so what condition (s)?_____
Do you have arch supports/orthotics in your shoes? Yes □ No □
Do you sleep well? Yes □ No □ Sometimes □
Do you have good energy? Yes □ No □ Sometimes □
Do you have a good appetite? Yes □ No □ Sometimes □
Are you under a lot of stress? Yes □ No □ Sometimes □
Do you smoke? Yes □ No □ Cigarettes? Marijuana? Vape? How often? _____
Do you drink alcohol? Yes □ No □ How often? _____
Do you exercise? Yes □ No □ What kind? _____
Are you under care for any other conditions? Yes □ No □ Which ones? _____
Have you had any surgeries? Yes □ No □ For what? _____
Any broken bones? Yes □ No □ Which ones? _____
What kind of water do you drink? □ Tap □ Bottled □ Spring □ Distilled □ Filtered
Females: Are you currently pregnant? Y □ N □ Due Date: _____
Check the following conditions you have NOW or HAVE HAD:
□ Arthritis □ Cancer □ Diabetes □ Heart Disease □ Back Problems □ Scoliosis
□ Alcoholism □ Constipation □ Allergy □ Anemia □ Arteriosclerosis □ Backaches □ Cold sores
□ Diarrhea □ Convulsions □ Emphysema □ Epilepsy □ Headache □ Menstrual Cramps
□ Low blood sugar □ Goiter □ Gout □ High Blood Pressure □ Heart Attack □ Heart disease
□ Irregular Periods □ Miscarriage □ Multiple Sclerosis □ Neuritis □ Nervousness □ Depression
□ Pleurisy □ Pneumonia□ Stroke □ Thyroid problems □ Ulcers □ Gall Bladder □ Whooping Cough

Please Go To Page 3:

If you are in pain <u>NOW</u>, how bad is it?
Please circle the appropriate number on this scale.

(No Pain) 1 2 3 4 5 6 7 8 9 10 (Worst Pain Imaginable)



A = Aching

B = Burning

N = Numbness

S = Stabbing

T = Tingling

W = Weakness

O = Other

What is your health goal for your complaint?

____ Patch care = pain relief
____ Fix Care = trying to get your body as near to normal as possible.

Please Go To Page 4:

Office Policies: The information on this application is accurate to the best of my knowledge. If I am accepted as a patient at the clinic, I understand that this is a cash clinic except for work and car accident injuries and that payment is due at the time of service unless other arrangements are made. I authorize all information to be released to get my bills paid. I authorize the Doctor to perform any services needed for my best care outcome, after he has answered all my questions. No information from my care here will be released to anyone without my written consent according to the HIPPA laws.

Consent to Treat: Although Doctor will do his best to help me, I also understand that no cures are promised or implied and any risks regarding care at this office will be explained to me upon my request. I now authorize the Doctor to proceed with any necessary treatment after all my questions have been answered. I have read the clinic's office policies and consent to treat information, and I agree with them by signing below:

Name (Print): _____

Signature: _____

Date: _____

Parent/Guardian's (required if patient is a minor):

Print: _____

Signature: _____

Date: _____

Thank you kindly for taking your time to fill out these forms.
We look forward to helping you and earning your referrals!

Dedicated To Your Health and Wellness,