

TENOLD CHIROPRACTIC HEALTH & REHAB CLINIC

www.tenoldchiropractic.com

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NEW PATIENT INFORMATION - ADULT

About you...

Name: First: _____ M.I.: _____ Last: _____ Date: _____

Street _____ City _____ State _____ Zip _____

Home Phone () _____ Work Phone () _____

DOB: / / Age: Male/Female Marital Status: married/single/divorced/widowed

Number of Children: SS# Work: full/part/self/retired/unemployed/military

Employer: _____

Address: _____ Occupation: _____

Emergency Contact ... *Not a member of your household*

Name: _____ Phone () _____

About your spouse...

Spouse's name: _____ Work Phone () _____

Spouse's employer: _____ Address: _____

Billing Information... (This is the person to whom the statements are sent.)

Person responsible for the account: _____
 Check box if same address as patient

Address: _____

SS# _____ DOB: / / Phone: () _____

Insurance company: _____ Phone: () _____

Name of Insured: _____ Auto accident Y / N Work injury Y / N

How did you hear about us? _____ Email address: _____

About your health...

In order of importance, what conditions are you most interested in correcting?

1.)

2.)

3.)

In order of severity, what functions are you unable to perform, i.e. sitting, bending, etc.?

1.)

2.)

3.)

What activities make your condition worse?

Is your condition: getting worse / getting better / constant / comes and goes

Is your condition interfering with: work / daily routine / sleep / other?

How long have you been in pain?

Have you been in an auto accident: Past twelve months? yes / no; One to five years ago? yes / no;
Over five years? yes / no; Never

Have you ever had a personal injury or accident? Past twelve months? yes/no;
One to five years ago? yes/no; Over five years? yes/no; Never

Have you ever had any mental or emotional disorders? yes / no When?

Have others in your family had such disorders? yes / no When?

Females: Are you currently pregnant? yes / no If yes, under care of :

Are you currently wearing: Heel lift yes / no Insoles yes / no Arch supports yes / no

Do you take vitamins or minerals? yes / no Please list.

Do you have an allergy to any drug? yes / no Please describe.

Current medication(s)... *List all medications that you are currently taking. Also note the reason you were prescribed the medication.*

Mark the appropriate sensation... Numbness >>> Pins & Needles ooo Burning xxx Stabbing /// Aching (((



I authorize the release of any medical or other information necessary to process this claim. I understand and agree that any amount authorized to be paid directly to Tenold Chiropractic will be credited to my account upon receipt. I clearly understand that if I suspend or terminated my care and treatment, any fee for professional services rendered me will be immediately due and payable. I further understand that in the event that my responsible party, insurance co., etc. does not cover the full amount, I will pay the balance of my account in full.

I understand that I am accepted as a patient of Tenold Chiropractic. I am authorizing them to proceed with any further treatment that may be necessary. Furthermore, any risks involving chiropractic treatment will be explained to me upon request.

Patient's signature _____ Date _____

Revised 01/20/2006
