The Human Engine Clinic
A Gringeri Chiropractic Corporation
3461 Picadilly Drive, San Jose, CA 95118 | 408-984-7444

NEW PATIENT FORM

Please provide us with the following information requested.

PATIENT NAME:_____ Sex: ☐M ☐F Age: ____Date of Birth _____
Address: _____ Soc. Security # _____
City, State, Zip _____ Home Phone # _____
Marital Status ☐S ☐M ☐W ☐SEP ☐DIV Number of Children: boys_____ girls: _____
Occupation: _____ Children's ages: _____
Employer: _____ Cell Phone # _____
Employer's Address: City _____ State _____ Zip _____

Spouse's Name: _____ Spouse' Soc. Security # _____
Employed by: _____ Spouse' work phone # _____
Nearest relative not living with patient: _____ Relationship: _____
Address of relative: City _____State ____ Zip _____Relative's Phone # _____
Were you referred by ☐Yourself ☐Friend ☐Insurance Carrier ☐Primary physician ☐Other physician?
Name of person who referred you: _____Their phone # _____
If different from above, who is your family physician? _____Phone # _____

FINANCIAL:	PRIMARY INSURANCE	SECONDARY PAYER OR RESPONSIBLE PARTY
NAME		
ADDRESS		
CITY, ST, ZIP		
POLICY #		
INSURED NAME		
RELATION		
SOC. SEC. #		
BIRTH DATE		
GROUP #		
EMPLOYER NAME		

I the undersigned hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my conditions(s). Further, I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process insurance claims. I understand that I am responsible for all charges which may include a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

Signature _____ Date_____

E-MAIL ADDRESS: _____

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NEW PATIENT FORM

WHAT PROBLEM BRINGS YOU TO SEE US TODAY?

WHEN DID THIS PROBLEM START?

WHAT CAUSED THE PROBLEM?

IF YOU WERE INJURED WAS IT:
- ☐ AT HOME
- ☐ AT WORK
- ☐ AUTO ACCIDENT
- ☐ OTHER PERSONAL INJURY

DID YOUR PAIN COME ON:
- ☐ SUDDENLY ☐ GRADUALLY

IS THE PAIN:
- ☐ CONSTANT ☐ ON AND OFF

ARE YOU ABLE TO:	YES	NO
SLEEP NORMALLY	☐	☐
DO DAILY ACTIVITIES	☐	☐
CARE FOR YOURSELF	☐	☐
FUNCTION NORMALLY	☐	☐

Have you had this problem before ☐ NO ☐ YES WHEN?

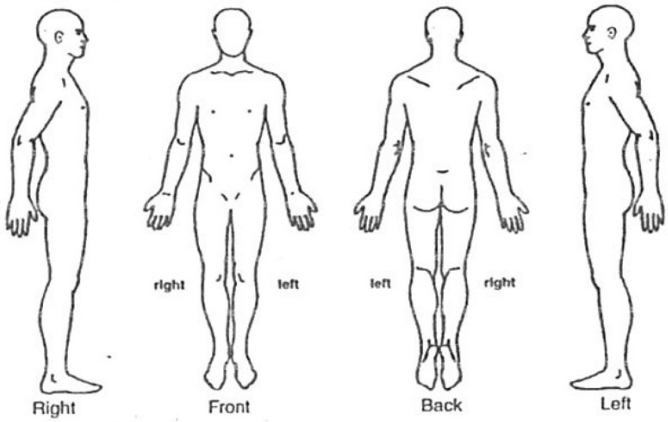
Who treated your last occurrence?

ON THE FIGURES AT THE RIGHT, PLEASE MARK YOUR AREA(S) OF PAIN OR DISCOMFORT.

+++	Burning	///	Stabbing
....	Pins & needles	XXX	No feeling

Circle the areas (if more than one) of pain and tell us on a scale of 1 to 10, with 1 being light pain to 10 being very severe, how severe is your pain in each area most of the time.

AREA 1 pain is (1-10) _____
AREA 2 pain is (1-10) _____
AREA 3 pain is (1-10) _____



Which words describes your pain MOST of the time?
- ☐ Constant
- ☐ On and Off
- ☐ Occasional
- ☐ Only at night
- ☐ Only on exertion
- ☐ Dull Ache
- ☐ Tingling
- ☐ Burning
- ☐ Throbbing
- ☐ Deep, stabbing
- ☐ Deep Achy
- ☐ Sharp recurring pain

How would you describe your current mobility?
- ☐ Self Mobile
- ☐ Need Walker
- ☐ Need Cane
- ☐ Need Wheelchair

Which best describes your current employment?
- ☐ Working ☐ full time ☐ Part time
- ☐ Unemployed
- ☐ On sick leave
- ☐ On temporary disability
- ☐ On permanent disability
- ☐ Retired

If on temporary or permanent disability or sick leave
Last full day of work was _____

PATIENT	ID#	DATE	BRIEF HISTORY & SYMPTOMS