Jeanne Barta, D.C.
1776 Ygnacio Valley Rd, Ste 106, Walnut Creek, CA 94598
(925)682-4941

# NEW PATIENT INFORMATION

Name _____

Home Phone_____Cell Phone_____

Address_____ City_____State_____Zip_____

Email address_____

Date of Birth_____Age____Sex: M____F____ Height_____Weight_____

SSN_____Drivers License #_____exp date_____

Employer_____Address_____City_____

State____Zip_____Phone_____Occupation_____

Name of Spouse_____Occupation_____

Emergency Contact_____Phone_____

Referred by: _____

## PAYMENT IS DUE AT THE TIME OF SERVICE

Assignment of benefits (if applicable): I hereby assign all medical benefits to which I am entitled, including Medicare, Automobile Medical Pay, Private insurance or any other health plans to Jeanne W. Barta, D.C.
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be as valid as an original.

I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

SIGNED:_____DATE:_____
(This form meets the California debt collection Fair Practices Act.)

Patient Name: _____

Family History

Parents Living: Father(age)_____ Mother(age)_____ Brothers_____ Sisters_____

Is there a family history of: Diabetes_____ Asthma_____ Cancer (type)_____

Mental disease_____ Heart disease_____ Lung disease_____ Arthritis_____

Allergies (type)_____ Other_____

Personal History

Childhood diseases: Measles_____ Mumps_____ Chicken Pox _____ Other_____

Unusual Childhood diseases_____

Do you smoke?_____ How many_____Do you drink coffee_____

How much?_____ Do you drink alcohol?_____ How much?_____

Do you take prescription meds? List names_____

Do you take vitamins? _____ List names_____

Do you exercise? _____ *Regularly* *Sometimes* *Seldom*

Are you pregnant now?_____ Date of last menstrual period_____

Do you have a pacemaker?_____

List hobbies _____

Past History

List any previous injuries with dates (slips, falls, auto accidents, sports, etc.)
_____
_____

Have you had previous back trouble? Yes____ No____. If yes, describe & give dates.
_____
_____

List any past significant illness_____

List all surgeries_____

List any known allergies_____

List all known abnormalities_____

Have you seen any other Chiropractor? Give name_____

Patient Name: _____

Last physical _____ Findings _____Last adjustment_____

Have you had any X-rays taken in the past 2 years? Yes No Where_____
What part of the body?_____

If you suffer from exhaustion or fatigue, describe in your own words how you feel and what time of the day or night you experience these symptoms, indicating whether they occur daily, occasionally,etc._____
_____
_____

Would you say you are under a lot of stress? Explain - _____
_____

Do you experience undue worry, difficulty concentration, forgetfulness, etc.?
_____
_____

Female: Do you experience any pain or discomfort before, during or after your menstrual cycle? Do you experience any discomfort during the cycle week (regardless of whether you menstruate, are in menopause or have had surgical removal of all or part of the female reproductive organs or skip your periods periodically.) During the week are you "grouchy?" Irritable? Have crying spells, feel uptight, more nervous, or specify any other problems -
_____
_____
_____
_____
_____

Do you suffer from any of these symptoms?

_____Headaches
_____Blurred vision
_____Dizziness
_____Morning fatigue
_____General fatigue
_____Labored breathing
_____Shortness of breath
_____Indigestion
_____Heartburn
_____Lump in throat
_____Throat constriction
_____Numbness
_____Fainting spells
_____Lightheadedness
_____Other_____

_____Swelling in the joints
_____Excessive gas
_____Constipation
_____Loose stools
_____Insomnia
_____Hot flashes
_____Poor memory
_____Sexual impotency
_____Excessive perspiration
_____Palpitations of the heart
_____Dry skin
_____Poor or excessive appetite
_____Night sweats
_____"Nerves"

List foods/drinks that you consume the most in a week's time_____
_____
_____

Patient Name: _____

Chief complaint (describe fully, and continue below or on back if necessary):

_____

_____

_____

_____

_____

Is your condition due to an accident or to an illness?

_____

_____

_____

If due to an auto accident or injury incurred at work, please specify _____

_____

When were you last seen by a physician? _____

For what purpose? _____

Your doctor's name _____Specialty_____

Address_____ City_____ State___ Zip_____

Telephone_____ Diagnosis by your doctor_____