

# DR. CRAIG A. HENNIE

HOME OF THE 15 MINUTE OR FREE GUARANTEE

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## NEW PATIENT INFORMATION

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ SSN# \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_

Zip \_\_\_\_\_ Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_ Marital Status: M S W

E-Mail Address \_\_\_\_\_ Employer \_\_\_\_\_

Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Work Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Parent/Spouse Name \_\_\_\_\_ SSN # \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Spouse's Birth date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ # of children \_\_\_\_\_ Ages \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Who were you referred by? \_\_\_\_\_

Is this condition work related? \_\_\_ If so, have you reported it to your employer? \_\_\_

Is this condition related to an auto accident? \_\_\_ Another accident? \_\_\_\_\_

List your chief complaints in order of severity?

1. \_\_\_\_\_ For how long? \_\_\_\_\_

2. \_\_\_\_\_ For how long? \_\_\_\_\_

3. \_\_\_\_\_ For how long? \_\_\_\_\_

List other doctors consulted for these conditions \_\_\_\_\_

Date of last physical exam \_\_\_\_\_ If female, are you pregnant? \_\_\_\_\_

Have you been under Chiropractic Care before? \_\_\_ If yes, when? \_\_\_\_\_

Name and address of your previous Chiropractor \_\_\_\_\_

Past Surgery \_\_\_\_\_

\_\_\_\_\_

Past Accidents \_\_\_\_\_

\_\_\_\_\_

Past Injuries \_\_\_\_\_

\_\_\_\_\_

Illness \_\_\_\_\_

\_\_\_\_\_

Past Disability Evaluation \_\_\_\_\_

Other Doctors you are presently seeing and reason \_\_\_\_\_

\_\_\_\_\_

Things you can no longer do that you used to do \_\_\_\_\_

\_\_\_\_\_

Do you have Major Medical or Health Insurance? \_\_\_\_\_ Company \_\_\_\_\_

Method of payment for today's charges: Cash Check Mastercard VISA Discover

Patient hereby agrees to pay said statement within fifteen (15) days from statement date. It is further agreed, that if payment is not remitted at the end of thirty (30) days from statement date, patient agrees to pay 15% service charge on the unpaid balance. Any unpaid balance not covered by Major Medical or Health Insurance or co-insurance is the responsibility of the patient. In the event this account is placed for collection, or collected by suit through any other, reasonable attorney fees and collection costs will be added.