*Ishitani Health Center*
*Excellence in Holistic Care*
1600 Parker Ave
Fort Lee, NJ 07024 201.302.9993
www.IshitaniHealth.com

***Bringing Out The Best In You!***

Chiropactic
Physical Therapy
Acupuncture
Naturopathy

# New Patient Welcome To Our Office

Date _____

Name _____ Preferred name _____

Address _____

City/State/Zip _____

Phone #s (home) _____ (cell) _____

Email address _____

SS # _____ Birthdate _____ Age _____

Occupation _____ Employer _____

Is it okay to contact you at work? ❍ no ❍ yes Work # _____

Marital status ❍ single ❍ married ❍ separated ❍ divorced ❍ widowed

Spouse's name _____ Phone #(s) _____

Children's names and ages _____

_____

Do you have any pets? ❍ no ❍ yes If yes, please tell us what kind(s) _____

_____

Favorite hobbies or interests _____

Emergency contact: Name _____

Relationship _____ Phone #(s) _____

## What Brings You Here?

Have you ever had chiropractic care before? ❍ no ❍ yes

If yes, please tell us who _____ Phone # _____

Were you pleased with your care? ❍ no ❍ yes

How did you find out about our office? _____

Is this appointment related to ❍ work ❍ sports ❍ auto
❍ personal injury ❍ other _____

When did the incident occur? _____

Attorney (if applicable) _____ Phone # _____

Are you receiving care from other health professionals? ❍ no ❍ yes

If yes, please name them and their specialty _____

_____

Please list any drugs or medications you are taking _____

_____

Please list any vitamins/herbs/homeopathics/other you are taking _____

_____

_____

Are you pregnant? ❍ no ❍ yes If yes, what month? _____

This form continues. Please turn the page.

## Current Health

In order of Importance , list the health problem you are most interested in getting corrected:

1:_____

2:_____

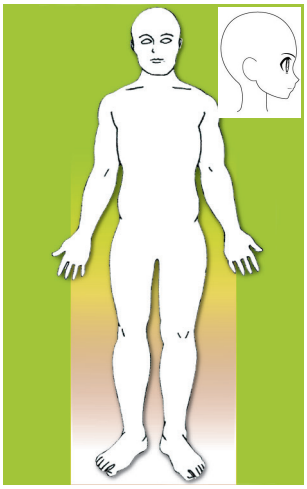
3:_____

4:_____

When was the first time you noticed this problem_____

Is it ❍ getting worse ❍ improving ❍ intermittent ❍ constant ❍ can't say

List those body functions that you are unable to perform or that produce pain upon performance.



1:_____

2:_____

3:_____

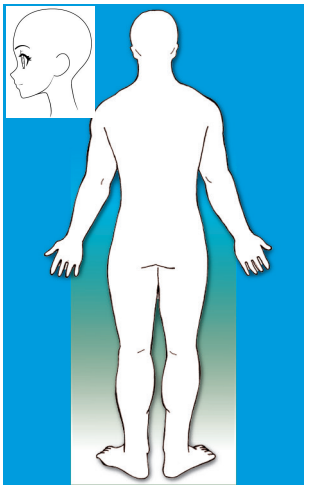
4:_____

1:_____

2:_____

3:_____

4:_____



Do you have ❍ pain ❍ numbness ❍ tingling ❍ aches

Is your pain ❍ sharp ❍ dull ❍ throbbing ❍ constant ❍ intermittent

Are your symptoms affected by : ( ) sitting ( ) standing ( )walking ( ) Bending ( ) lying down

( ) weather ( ) other _____

Do you feel ❍ cramps ❍ burning ❍ stiffness ❍ swelling ❍ other

Please explain_____

_____

Do your symptoms interfere with ❍ work ❍ sleep ❍ day-to-day activities

❍ play ❍ other _____

Have you had any similar health problems or injuries before :_____

_____

_____

Descrbe any accidents, falls, injuries, sudden movements, etc, that may have caused your problems :

_____

_____

_____

## Health History

Do you have, or have you had, any of the following (please check ✓ all that apply)?

❍ pneumonia ❍ mumps ❍ influenza ❍ rheumatic fever ❍ smallpox
❍ pleurisy ❍ polio ❍ chickenpox ❍ thyroid disease ❍ diabetes
❍ epilepsy ❍ cancer ❍ depression ❍ whooping cough ❍ anemia
❍ eczema ❍ measles ❍ arthritis ❍ heart disease ❍ rashes
❍ colitis ❍ stroke ❍ allergies _____

If you have ever been diagnosed with another disease or condition, please describe _____

_____

Do you drink ❍ coffee ❍ tea ❍ alcohol

Do you use ❍ cigarettes ❍ recreational drugs ❍ artificial sweeteners ❍ sugar

Have you ever suffered from (please check ✓ all that apply)

❍ neck pain ❍ difficulty breathing ❍ discolored urine
❍ low back pain ❍ stuffy nose ❍ gas/bloating after meals
❍ headache ❍ fainting ❍ heartburn
❍ migraines ❍ weight loss ❍ irritable bowel
❍ arm pain/tingling ❍ poor appetite ❍ black or bloody stools
❍ shoulder pain ❍ excessive appetite ❍ constipation
❍ hand pain/tingling ❍ nervousness ❍ hemorrhoids
❍ leg pain/tingling ❍ confusion ❍ liver problems
❍ jaw pain ❍ depression ❍ paralysis
❍ chest pain ❍ dental problems ❍ numbness
❍ lung problems ❍ excessive thirst ❍ fatigue
❍ heart problems ❍ frequent nausea ❍ dizziness
❍ abnormal blood pressure ❍ prostate problem ❍ loss of sleep
❍ irregular heartbeat ❍ breast pain/lump ❍ difficulty hearing
❍ ankle swelling ❍ cramps ❍ ear pain
❍ cold extremities ❍ painful urination ❍ other _____
❍ blurred vision ❍ bladder trouble _____
❍ vision problems ❍ excessive urination _____

If applicable, date of last menstrual period _____

Past injuries can affect present health (please check ✓ all that apply)

❍ falls/accidents ❍ head injuries ❍ fights ❍ surgery
❍ sports injuries ❍ broken bones ❍ dislocations ❍ other
❍ spinal tap ❍ knocked unconscious ❍ traction _____
❍ use(d) a cane or walker ❍ extensive dental work ❍ dental applications _____

If yes to any of the above, please describe _____

_____

_____

_____

_____

## What Do You Know About Chiropractic?

In your own words, what do chiropractors do? _____

_____

Do you know what a subluxation is? ❍ no ❍ yes

If yes, please describe _____

_____

Do any friends or relatives see chiropractors: ❍ no ❍ yes

If yes, do they use chiropractic for ❍ health maintenance/optimization

❍ health problems ❍ both

Are you seeking chiropractic for ❍ health maintenance/optimization

❍ health problems ❍ both

What would you like to gain from chiropractic care? _____

_____

_____

Are there other health concerns or anything else you'd like us to know about you? ❍ no ❍ yes

If yes, please tell us _____

Your general health and wellbeing are causally linked to the quality and quantity of food your inlet.

We offer a comprehensive Nutritional consultation as part of your initial exam with Dr. Humaira ND,

this service is substantially discounted for our patients and might be covered by your insurance.

This can include nutritional protocols and or supplemental addition for your specific health concerns

Please check this box if you like to hear more: ☐

healthy body happy me 2020

## Financial Responsibility

Who is responsible for payment? _____

How will you pay for your care? ❍ Cash ❍ Check ❍ Credit Card

Insurance co. _____ Phone # _____

ID # _____ Group # _____

Subscribers's name _____ Phone # _____

Relation _____ Subscriber's employer _____

Subscriber's birthdate _____

The above is accurate to the best of my knowledge.

_____ _____

(signature) (date)

I, parent/guardian, give permission for minor's care.

_____ _____

(signature) (date)