Gruber Chiropractic

New Patient Form

Please notify Dr. Gruber if there is any chance of pregnancy

Patient Name: ________________ Age: ________ Birthdate____________ Sex: M / F
Address: ________________ City: ____________ State: ________ Zip: ________
Phone: ____________ Social Security #: ____________ Driver Lic. #: ____________
Occupation: ____________ Employer: ________________ Phone: ____________
Address: ________________ City: ____________ State: ________ Zip: ________
Subscriber Name: ________________ Health Plan: ________________
Subscriber ID# ____________ Group #: ____________ Spouse Name: ____________
Spouse Empoyer: ____________ City: ____________ State: ________ Zip: ________

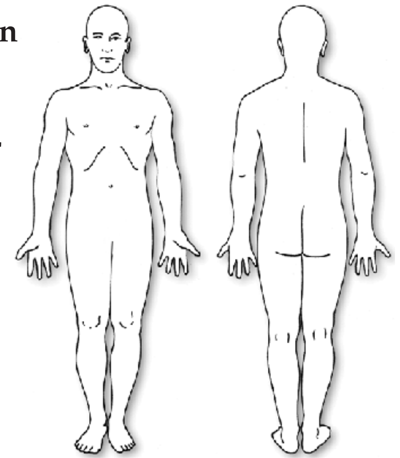
Describe your current problem and how it began:

____
____
____

Is this... ❑ Work Related ❑ Auto Related ❑ N/A

Date problem began: ________________

Mark an X on the picture where you have pain or other symptoms.



Current complaint (how you feel today):

|______________________________________|

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

How often are your symptoms present? ❑ **0 - 25%** ❑ **26 - 50%** ❑ **51 - 75%** ❑ **76 - 100%**

Can you perform your daily activities? ❑ Yes ❑ No (Describe)________________

____

Have you had spinal X-Rays, MRI, CT Scan? ❑ No ❑ Yes (Dates taken)________________

What areas were taken?________________________________

Please check all of the following that apply to you:

Past	Present	Condition	Past	Present	Condition
❑	❑	History of Recent Infection	❑	❑	Prostate Problems
❑	❑	Fever	❑	❑	Frequent Urination
❑	❑	HIV/AIDS	❑	❑	Pregnancy, # of births_______
❑	❑	Diabetes	❑	❑	Abnormal Weight ❑ Gain ❑ Loss
❑	❑	Corticosteroid Use	❑	❑	Epilepsy/Seizures
❑	❑	Birth Control Pills	❑	❑	Visual Disturbances
❑	❑	High Blood Pressure	❑	❑	Low/Mid Back Pain
❑	❑	Stroke (date)____________	❑	❑	Neck Pain
❑	❑	Dizziness/Fainting	❑	❑	Arthritis
❑	❑	Numbness in Groin/Buttocks	❑	❑	Alcohol Use
❑	❑	Urinary Retention	❑	❑	Tobacco Use
❑	❑	Aortic Aneurysm	❑	❑	Surgeries/Medications:__________
❑	❑	Cancer/Tumor			________________
❑	❑	Osteoporosis			________________
❑	❑	Trauma			________________

Family History: ❑ Cancer ❑ Diabetes ❑ High Blood Pressure ❑ Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: ________________________________ Date: ________________