

**Caminez Chiropractic and Wellness Center**  
**Dr. Brett Caminez**

**NEW PATIENT APPLICATION FOR CARE**

*Welcome to our practice! Please thoroughly complete all questions. All information is Confidential.*

---

---

Name: \_\_\_\_\_ Referred by: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_ # of Children: \_\_\_\_\_ SS#: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Work Address: \_\_\_\_\_

Do you have insurance? Yes or No **(If yes, please give the front desk your card to copy)** Are you the primary cardholder? Yes or No

Name of Insurance Company: \_\_\_\_\_

**(If no)**, Name of primary cardholder \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Method of payment for first visit: \_\_\_\_\_ Cash \_\_\_\_\_ Check \_\_\_\_\_ Credit Card

---

---

Health reasons for consulting our office: 1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

Date of Onset? \_\_\_\_\_

What are you hoping Chiropractic care can do for you? \_\_\_\_\_

Have you had this condition before? \_\_\_\_\_ If yes, when? \_\_\_\_\_

Is this a result of an auto or work injury: \_\_\_\_\_ Date of Accident: \_\_\_\_\_ Have you lost days from work? \_\_\_\_\_

What other doctors have you seen for this condition? \_\_\_\_\_

What did they do? \_\_\_\_\_

Mother/Father/Brother/Sister/Children with similar problems? \_\_\_\_\_

When was your last visit to a Chiropractor? \_\_\_\_\_ Were you helped? \_\_\_\_\_

What Spinal Correction programs were you given? \_\_\_\_\_

Did you follow it? \_\_\_\_\_ If not, why? \_\_\_\_\_

How did the post X-Rays look? \_\_\_\_\_

What daily rituals for spinal health do you presently practice? \_\_\_\_\_

---

---

Who is your General Practitioner? \_\_\_\_\_ Phone: \_\_\_\_\_

City, State: \_\_\_\_\_

Other Specialists you are currently under care with:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

I \_\_\_\_\_ hereby give permission to forward relevant information regarding my care to the above stated doctors

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



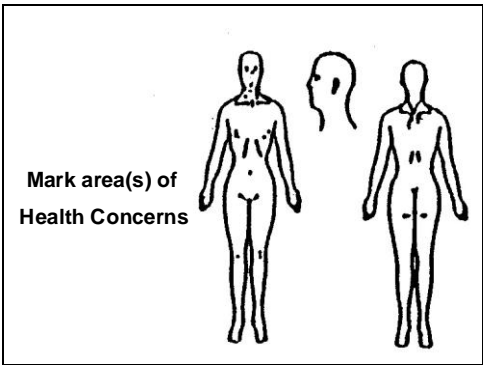
What surgeries have you had? \_\_\_\_\_

List medications you now take (prescription & non-prescription): \_\_\_\_\_

What are your favorite hobbies/interests? \_\_\_\_\_

**Please mark X for present conditions, O for past conditions**

- |                              |                                      |   |                               |
|------------------------------|--------------------------------------|---|-------------------------------|
| _____ Fractured Bones        | _____ Sinus Problems                 | _____ Fainting                              | _____ Gall Bladder Trouble    |
| _____ Auto Accidents         | _____ Eating Disorders               | _____ Loss of Balance                       | _____ Digestive Problems      |
| _____ 0-1 years ago          | _____ Trouble Sleeping               | _____ Blurred Vision R L                    | _____ Heartburn               |
| _____ 1-5 years ago          | _____ Trouble Concentrating          | _____ Double Vision R L                     | _____ AIDS/HIV                |
| _____ More than 5            | _____ Learning Disability            | _____ Upper Back Pain/Stiffness             | _____ High/Low Blood Pressure |
| _____ Other Accidents/Falls  | _____ Mid Back Pain/Stiffness        | _____ Ulcers                                | _____ Cancer –Type_____       |
| _____ Stroke                 | _____ Headache                       | _____ Low Back Pain/Stiffness               | _____ Diarrhea/Constipation   |
| _____ Arthritis              | _____ Pain/Stiff Neck R L            | _____ Numbness, Tingling or Pain            | _____ Menopausal Problems     |
| _____ Diabetes               | _____ Numbness/Tingling/Pain         | _____ in buttocks, thighs, legs, feet, toes |                               |
| _____ Swollen/Painful Joints | _____ Arms/Hands/Fingers/Wrists R L  | _____ Hearing Loss R L                      |                               |
| _____ Convulsions/Epilepsy   | _____ Jaw Pain/TMJ R L               | _____ Hip Pain R L                          |                               |
| _____ Skin Problems          | _____ Head/Shoulders Feel Tired      | _____ Foot Trouble R L                      |                               |
| _____ Pregnant (now)         | _____ Difficulty in Excessive        | _____ Chest Pain                            |                               |
| _____ Frequent Colds/Flu     | (Standing, Walking, Bending, Riding, | _____ PMS / Menstrual Problems              |                               |
| _____ Depressed              | Twisting, Lifting, Household Duties) | _____ Dizziness                             |                               |
| _____ Irritable              | _____ Shoulder Pain R L              | _____ Difficulty Breathing                  |                               |
| _____ Heart Problems         | _____ Kidney Trouble                 | _____ Ringing in Ears R L                   |                               |
| _____ Asthma                 | _____ Prostate Problems              | _____ Allergies                             |                               |



**If patient is a minor (under 18yrs old), Please fill out this section. If not, skip:**

Parent/ Guardian's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ SS#: \_\_\_\_\_

**Consent to evaluate and adjust a minor child**

I, \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_ have read and fully understand the terms of acceptance and hereby grant permission for my child to receive chiropractic care.

**Pregnancy release**

This is to certify that to the best of my knowledge I am not pregnant and the doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and the potential for improvement.

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_