Nu-Chiropractic
Dr. Doug Paul
1335 Dublin Rd., Suite 75-A Columbus, OH 43215

CONFIDENTIAL PATIENT INFORMATION

Please complete this questionnaire and the following forms. Your answers will help us determine if our care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. This information will also help us to get to know you as a person and will help us determine how we can best meet your needs.

Name _____ Social Security #_____-_____-_____

How do you wish to be addressed in our office? First name Dr. Mr. Mrs. Miss Ms.

Address_____ City_____ State _____ Zip_____

Home Telephone_____Cell Phone_____ email_____

Age_____ Birth date_____ Marital status: M S D W

Employer_____Phone_____Address_____City_____

St._____ Zip_____ Occupation _____ Hobbies/interests_____

Spouse's Name_____ Birth Date_____Employer_____

Number of children_____ How did you learn about our office?_____

Name of nearest relative not living with you_____

Address _____ City _____ State _____ Zip_____

Health Information:

Family Physician_____

Dentist_____

Other (massage therapist, etc.)_____

Reason For Consulting The Office (check all that apply)

_____ I have a specific problem and require only help with this problem.

_____ After my specific problem has been relieved, I am interested in strategies to insure the problem does not return.

_____ After my specific problem has been resolved and I understand methods to insure it does not return, I am interested in strategies to improve my general health.

_____ I have no symptoms and I feel well. I am interested in strategies to help me continue to feel well, or even better.

_____ I want optimum health and wellness. I want to be the very best that I can be in all aspects of my life.

SIGNATURE AUTHORIZING CARE_____ DATE_____