Dr. Michael Tereo, *Practice of Chiropractic and Nutrition* ◆ (510) 944-4794 ◆ drmtereo@gmail.com

NEW PATIENT INFORMATION FORM

NAME: _____ DOB: _____ AGE: _____ GENDER: M F

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CELL #: _____ SSN: _____ STATUS: M W D S

HOME PHONE #: _____ WORK #: _____ EMAIL: _____

HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____ CHILDREN (How many): _____

OCCUPATION: _____ EMPLOYER: _____

_____

CHIEF COMPLAIN (What brings you to our office?): _____

_____

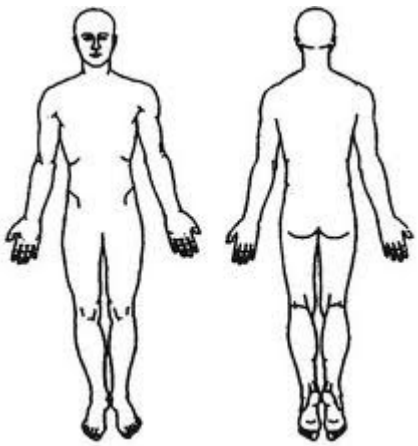
_____

_____

_____

_____

_____



On The Pain Drawing above please place a circle on each area where you experience symptoms. Make sure to include all areas.

HOW BAD IS YOUR PAIN? (Please Circle a Number)

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

HOW OFTEN ARE YOUR SYMPTOMS PRESENT?

❑ 0 to 25% ❑ 26 to 50% ❑ 51 to 75% ❑ 76 to 100%

PLEASE CHECK OFF ALL ACTIVITIES THAT ARE AFFECTED BY YOUR CONDITION (s):

❑ sleep ❑ sitting ❑ standing ❑ walking ❑ lifting ❑ bending ❑ stooping ❑ squatting ❑ putting on shoes and socks
❑ grasping ❑ mouse usage ❑ keystroking ❑ chopping vegetables ❑ cooking ❑ cleaning ❑ vacuuming ❑ reaching ❑ pulling

NOTICE OF UNDERSTANDING AND AGREEMENT : I hereby attest to the following:

1. I fully understand the Practitioner I am seeing in this office is not a physician, and I am not consulting for medical, diagnostic, or treatment procedures.
2. The services performed by the Practitioner are at all times restricted to helping me gain a better understanding of my degree of "health" not disease, so I will have a greater self-awareness and be able to use a self-care program for daily living.
3. I understand that the recommendations, discussion, sale of food, nutrition, nutritional supplements, vitamins or minerals, food grade herbs, or other nutrients as foods for special dietary use only pertains to the whole body concept of nutrition, and does not relate in the context of any specific ailment or condition.
4. The appointments do not involve the diagnosing, prognosticating, treating or prescribing of medicines or the treatment of disease, or any act which will constitute the practice of medicine in this state, for which a license is required.

I, _____, have read and understand the above.

(print name)

Signature: _____ Date: _____ Referred by: _____