New Patient Form

12271 State Highway T, Grant City, MO 64456
(816) 244-0613
DrDylanMiller.com

Miller Chiropractic

Date

PERSONAL INFORMATION

Name

Address

City/State/Zip

Home Phone Work Phone Cell Phone

Email Females: Last Menstral Period:

Date of Birth Pregnant Y ☐ N ☐ Nursing Y ☐ N ☐

Marital Status S ☐ M ☐ D ☐ W ☐ Sex M ☐ F ☐ Age

Occupation Referred By

Emergency Contact Name/Phone

Spouse / Parent / Guardian

CURRENT HEALTH CONDITION

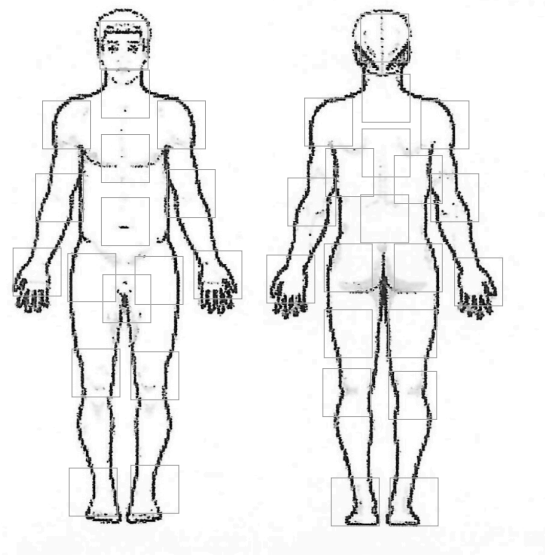
Purpose of this appointment

Today's condition started when ?

Medications: Please check and list all medications that you are currently taking with the date you began taking them.

- ☐ Antacids
- ☐ Antibiotics
- ☐ Antidepressants
- ☐ Anti-Diabetic
- ☐ Anti-Inflammatory
- ☐ Arthritis Drugs
- ☐ Behavioral Modification Drugs
- ☐ Blood Pressure Lowering Drugs
- ☐ Cholesterol Lowering Drugs
- ☐ Hormone Replacements
- ☐ Birth Control
- ☐ Weight Loss
- ☐ Other

Mark problem areas on the chart below.



YOUR LIFESTYLE

- Alcohol
- Tobacco
- Marijuana
- Drugs
- Stress
- Occupational hazards
- Regular exercise
- Type Frequency
- Type Frequency

FEMALES, PLEASE COMPLETE

- Pregnant
- Planning pregnancy
- Menstrual flow irregular/pain
- Days of flow
- Length of cycle
- First day of your last period
- Pain/Bleeding during or after sex

Number of:
Pregnancies
Abortions
Miscarriages
Live births
Birth control method
Birth control pill name

- Flushing/Menopause

Date of last PAP test

- Normal
- Abnormal

Date of last mammogram

- Normal
- Abnormal

HOSPITALIZATIONS, SERIOUS ILLNESS, SURGERIES

Date
Reason

Date
Reason

Date
Reason

Date
Reason

MEDICAL HISTORY

- Ringing in ear
- Frequent ear infections
- Dizziness/Fainting
- Failing vision
- Eye infections
- Nose bleeds
- Sinus trouble
- Frequent sore throats
- Hayfever/ Allergies
- Pneumonia
- Bronchitis/Chronic cough
- Asthma/Wheezing
- Chest pain
- High blood pressure
- Heart trouble
- Swollen ankles
- Leg pain (walking)
- Varicose veins/phlebitis
- Loss of appetite
- Difficulty swallowing
- Indigestion/Heartburn
- Persistent nausea/vomiting
- Ulcers
- Chronic abdominal pain
- Gall bladder trouble
- Jaundice/Hepatitis
- Change in bowel habits
- Diarrhea
- Constipation
- Diverticulosis
- Crohn's/Colitis
- Bloody/Tarry stools
- Hemorrhoids
- Hernia
- Glaucoma
- Parasites
- Yeast/Candida
- Urinary Trouble
- HIV/AIDS
- Decrease in force/flow of urinatio
- Recent weight loss
- Anemia
- Bruise easily
- Cancer
- Kidney stones
- Venereal disease
- Chronic fatigue
- Diabetes
- Thyroid disease
- Convulsions/Seizures
- Stroke
- Tremor/Hands shaking
- Muscle weakness
- Numbness/Tingling sensations
- Frequent headaches
- Arthritis/Rheumatism
- Osteoporosis
- Recurrent back pain
- Bone fracture/join injury
- Gout
- Foot Pain
- Numbness
- Rashes/Hives
- Psoriasis
- Eczema
- Nervousness
- Depression
- Memory loss
- Excessive moodiness
- Mental illness
- Phobias
- Lactose intolerance
- Prostate problems
- Frequent infections
- Trauma/Abuse
- Physical Abuse
- Emotional Abuse
- Verbal Abuse
- Sexual Abuse
- Financial Stress
- Other

FAMILY HISTORY (Have any blood relatives had the following illnesses? If so, please indicate the relationship.)

Illness	Family Members
Diabetes	
Cancer	
Blood disease	
Glaucoma	
Epilepsy	
Rheumatoid Arthritis	
Tuberculosis	
Gout	
High blood pressure	
Heart disease	
Other	

DISCLAIMER: By typing your name below, you are signing this form electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this form.

PAYMENT IS EXPECTED AT TIME OF VISIT, EXAMINATION CONSENT, AND PATIENT HEALTH INFORMATION (PHI) AGREEMENT

I understand that all services at Miller Chiropractic are on a cash, check, or credit/debit card basis, payable at each appointment, and I am personally responsible for any debts incurred, including for missed appointments without 24-hour cancellation notice, regardless of insurance arrangements, consent to Dr. Dylan Miller using Professional Applied Kinesiology (PAK) and Diagnostic Muscle Testing—evaluating functional health, not diagnosing disease—combined with medical history and testing to diagnose and treat my condition, and I permit necessary procedures. I also agree that Miller Chiropractic may use my Patient Health Information (PHI) for treatment, payment, operations, and care coordination; I can access my records, request disclosure details, or revoke consent in writing (effective post-request), knowing my privacy is protected by trained staff at 12271 State Highway T, Grant City, MO 64456

Name of Person Responsible for Payment:

Address & Phone (if different than yours):

Date:

Signature or Initials:

Dr. Dylan Miller
12271 Hwy T
Grant City, MO 64456
(816) 244-0613

Patient Name:_____

DOS: