New Patient Information

Name: _____ SSN: _____ Age: _____ DOB: _____

Address: _____ Apt: _____ City: _____ State: _____ Zip Code: _____

Email Address: _____ Cell Phone: _____ Home Phone: _____

Preferred Phone Number: Cell / Home / Work Would you like text appointment reminders: Yes / No If yes, carrier: _____

Employer: _____ Occupation: _____ Work Phone: _____

Sex: Male / Female Marital Status: Single / Married/ Divorced / Widowed

Spouse: _____ DOB: _____

Emergency Contact Name: _____ Emergency Contact Number: _____

General Physician: _____ Phone: _____

May we contact your doctor regarding care in our office: Yes / No

Have you seen a chiropractor before: Yes / No If yes, when was your last visit: _____

Who can we thank for referring you to our office: _____

Is your present condition a result of a slip/fall: Yes / No Date: _____

Is your present condition a related to an auto accident: Yes / No Date: _____

Is your condition an injury that occurred on the job: Yes / No Date: _____

_____ _____

Patient Signature (Legal Representative if patient is a minor) Date

Case History

Patient Name: _____ Date: _____

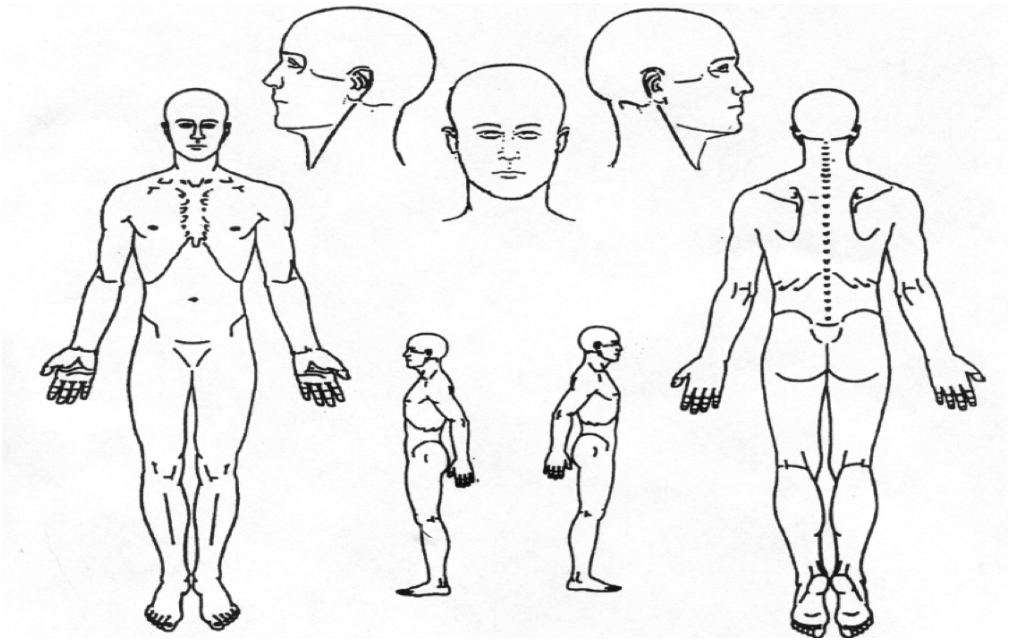
Height: _____ Weight: _____ Lenses: Y / N If yes, Far Sided / Near Sided Right Handed / Left Handed

Primary reason for seeking chiropractic care and rate your pain level on a scale 0 to 10 (10 being the worst possible pain):

1. _____

PLEASE IDENTIFY AND MARK YOUR AREA OF COMPLAINT AS FOLLOWS:
Please mark on the body to the right of the area of complaint(s) with the abbreviations:

A – ache B – Burning N- Numbness P – Pins and Needles S – Stabbing O - Other



What is the frequency of the discomfort you are feeling: Circle One

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How would you rate the discomfort **at it's best**: Circle One

0 1 2 3 4 5 6 7 8 9 10

How would you rate the discomfort **at it's worst**: Circle One

0 1 2 3 4 5 6 7 8 9 10

Describe the onset of the discomfort: Gradual / Sudden

When did the discomfort begin: ___hours ago ___days ago ___weeks ago ___months ago ___years ago

Complaint

Have you ever experienced this complaint before? ◯ NO ◯ YES

If yes, When? _____

Have you received treatment from another healthcare provider for this complaint? ◯ NO ◯ YES

If yes, how long ago? And did you get relief?_____

Do you know the cause of your complaint(s)? ◯ NO ◯ YES If yes, please describe_____

_____

What is the frequency of your pain / symptoms (time of day, how often occurs during the day or evening, etc):

_____

_____

What makes your symptoms better? _____

_____

What makes your symptoms worse? _____

_____

Do you have any previous illnesses or injuries which relate to these complaints/symptoms? ◯ NO ◯ YES

If yes, please describe: _____

_____

Have you ever been hospitalized or had surgery? ◯ NO ◯ YES

If yes, please describe: _____

_____

Are you currently taking medication(s) (prescription and non prescription)? ◯ NO ◯ YES If yes, please complete the following:

Name of medication: Dosage : Reason taking and for how long:

_____

_____

_____

Are you taking any vitamins and/or supplements? ◯ NO ◯ YES If yes, please complete the following:

Name of Vitamin/supplement: Dosage: Reason for taking:

_____

_____

_____

Lifestyle

Tobacco _____ Coffee (cups/day) _____ Tea (glasses/day) _____ Soft drinks: diet or reg (#/day) _____

Alcohol (drinks/day) _____ Sleep (hrs/day) _____ Do you feel rested after sleep? ◯ NO ◯ YES

Exercise: NONE Light (1-2 x/week) Moderate (3-4 x/week) Athletic (4 or more x/week)

Would you say your over diet is: Poor Fair Good Excellent

Any unexplained weight loss or gain in the past 6 months? ◯ NO ◯ YES If yes, how much gain / loss_____

Family History

Is there family history of any of the following conditions, if so please list immediate family relation (mother, father, sister, brother, grandmother (maternal or paternal) and grandfather (maternal or paternal):

Stroke:_____

Trans-ischemic attacks (mini strokes):_____

Atherosclerosis:_____

Heart disease:_____

Diabetes:_____

Cancer (type):_____

High blood pressure:_____

Please **circle** the symptoms or conditions you **currently have** and **underline** the symptoms or conditions you **have had in the past.**

General
Loss of memory
Depression
Headache
Fever
Chills
Night Sweats
Fainting
Dizziness
Convulsions
Loss of sleep
Fatigue
Nervousness
Tingling/Numbness
Confusion

Gastro-intestinal
Upset stomach
Poor appetite
Excessive Hunger
Belching or gas
Poor digestion
Nausea
Vomiting
Vomiting blood
Pain over stomach
Constipation
Diarrhea
Hemorrhoids
Liver trouble
Gall bladder trouble

Eye/Ear/Throat/Nose
Sensitivity to light
Crossed eyes
Pain in eyes
Deafness
Earache
Ringing in ear
Loss of smell
Nose bleeds
Sore throat
Allergies
Asthma
Frequent colds
Sinus trouble

Respiratory
Chronic cough
Spitting up blood
Spitting phlegm
Chest pain
Difficulty breathing
Shortness of breath

Muscles and Joints
Heaviness of head
Weakness
Twitching
Stiff neck/pain
Swollen joints
Loss of balance

Urinary
Frequent urination
Painful urination
Blood in urine
Kidney infection
Bed wetting
Urine control inability
Prostate trouble

Cardiovascular
Rapid heart beat
Slow heart beat
High blood pressure
Low blood pressure
Swelling in ankles
Varicose veins
Cold hands/feet

Skin
Skin eruptions Itching
Bruise easily Dryness
Sensitive skin Eczema

For Women Only
Breast Augmentation
Birth control
Painful periods
Excessive flow
Irregular cycles
Hot flashes
Miscarriage

I understand the above information and guarantee this form was completed correctly and to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

_____ _____

Patient or Legal Guardian Signature Date