

CHIROPRACTIC

Bringing Out The Best In You

New Patient

Welcome To Our Office

Patient _____
 Doctor _____
 Date _____ Case # _____



Name _____ Preferred name _____
 Address _____
 City/State/Zip _____
 Phone #s (home) _____ (cell) _____
 Is it okay to contact you at work? no yes Work # _____
 E-mail address _____ Web site _____
 SS# _____ Birthdate _____ Age _____
 Occupation _____ Employer _____
 Marital status single married separated divorced widowed
 Spouse's name _____ Phone #(s) _____
 Children's names and ages _____

Do you have any pets? no yes If yes, please tell us what kind(s) _____

Emergency contact: Name _____
 Relationship _____ Phone #(s) _____
 Favorite hobbies or interests _____

What Brings You Here?

Have you ever had chiropractic care before? no yes
 If yes, please tell us the doctor's name _____
 Were you pleased with your care? no yes
 How did you find out about our office? _____
 Is this appointment related to work sports auto
 personal injury other _____
 When did the incident occur? _____
 Attorney (if applicable) _____ Phone _____
 Are you receiving care from other health professionals? no yes
 If yes, please name them and their specialty _____

Please list any drugs or medications you are taking _____

Please list any vitamins/herbs/homeopathics/other you are taking _____

Are you pregnant? no yes If yes, what month? _____



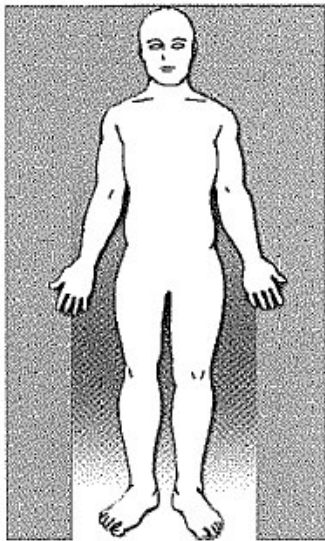
Current Health

What are your most pressing health concerns? _____

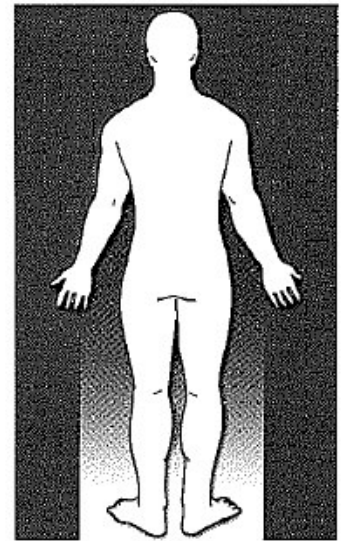
For how long? _____

Is it getting worse improving intermittent
 constant can't say

Where is the problem? Please use the illustrations and lines below to explain.



Front _____



Back _____

Do you have pain numbness tingling aches
 Is your pain sharp dull throbbing constant intermittent
 Are your symptoms sitting standing walking
 affected by bending lying down weather

Please explain _____

Do you feel cramps burning other
 swelling stiffness _____

Do your symptoms work sleep other
 interfere with day-to-day activities play _____

Please explain _____

On a scale of 1-10 (1 least, 10 most), please rate:

The severity of your symptoms 1 2 3 4 5 6 7 8 9 10



Health History

Do you have, or have you had, any of the following (*please check all that apply*)

- | | | | | |
|------------------------------------|----------------------------------|-------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> pneumonia | <input type="checkbox"/> mumps | <input type="checkbox"/> influenza | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> smallpox |
| <input type="checkbox"/> pleurisy | <input type="checkbox"/> polio | <input type="checkbox"/> chickenpox | <input type="checkbox"/> thyroid disease | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> epilepsy | <input type="checkbox"/> cancer | <input type="checkbox"/> depression | <input type="checkbox"/> whooping cough | <input type="checkbox"/> anemia |
| <input type="checkbox"/> eczema | <input type="checkbox"/> measles | <input type="checkbox"/> arthritis | <input type="checkbox"/> heart disease | <input type="checkbox"/> rashes |

If you have ever been diagnosed with another disease or condition, please describe _____

- Do you use
- | | | | |
|----------------------------------|-------------------------------------|--|--------------------------------|
| <input type="checkbox"/> coffee | <input type="checkbox"/> tea | <input type="checkbox"/> artificial sweeteners | <input type="checkbox"/> sugar |
| <input type="checkbox"/> alcohol | <input type="checkbox"/> cigarettes | <input type="checkbox"/> recreational drugs | |

Have you ever suffered from (*please check all that apply*)

- | | | |
|--|--|---|
| <input type="checkbox"/> neck pain | <input type="checkbox"/> stuffy nose | <input type="checkbox"/> discolored urine |
| <input type="checkbox"/> low back pain | <input type="checkbox"/> allergies | <input type="checkbox"/> gas/bloating after meals |
| <input type="checkbox"/> headache | <input type="checkbox"/> fainting | <input type="checkbox"/> heartburn |
| <input type="checkbox"/> migraines | <input type="checkbox"/> weight loss | <input type="checkbox"/> colitis |
| <input type="checkbox"/> arm back/tingling | <input type="checkbox"/> poor appetite | <input type="checkbox"/> irritable bowel |
| <input type="checkbox"/> shoulder pain | <input type="checkbox"/> excessive appetite | <input type="checkbox"/> black or bloody stools |
| <input type="checkbox"/> hand pain/tingling | <input type="checkbox"/> nervousness | <input type="checkbox"/> constipation |
| <input type="checkbox"/> leg pain/tingling | <input type="checkbox"/> confusion | <input type="checkbox"/> hemorrhoids |
| <input type="checkbox"/> jaw pain | <input type="checkbox"/> depression | <input type="checkbox"/> liver problems |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> dental problems | <input type="checkbox"/> stroke |
| <input type="checkbox"/> lung problems | <input type="checkbox"/> excessive thirst | <input type="checkbox"/> paralysis |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> frequent nausea | <input type="checkbox"/> tingling |
| <input type="checkbox"/> abnormal blood pressure | <input type="checkbox"/> vomiting | <input type="checkbox"/> numbness |
| <input type="checkbox"/> irregular heartbeat | <input type="checkbox"/> prostate problem | <input type="checkbox"/> fatigue |
| <input type="checkbox"/> ankle swelling | <input type="checkbox"/> breast pain/lump | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> cold extremities | <input type="checkbox"/> cramps | <input type="checkbox"/> loss of sleep |
| <input type="checkbox"/> blurred vision | <input type="checkbox"/> painful urination | <input type="checkbox"/> difficulty hearing |
| <input type="checkbox"/> vision problems | <input type="checkbox"/> bladder trouble | <input type="checkbox"/> ear pain |
| <input type="checkbox"/> difficulty breathing | <input type="checkbox"/> excessive urination | |

If applicable, date of last menstrual period _____

Past injuries can affect present health (*please check all that apply*)

- | | | |
|--|--|--|
| <input type="checkbox"/> falls/accidents | <input type="checkbox"/> head injuries | <input type="checkbox"/> fights |
| <input type="checkbox"/> sports injuries | <input type="checkbox"/> broken bones | <input type="checkbox"/> dislocations |
| <input type="checkbox"/> spinal tap | <input type="checkbox"/> surgery | <input type="checkbox"/> traction |
| <input type="checkbox"/> use(d) a cane or walker | <input type="checkbox"/> extensive dental work | <input type="checkbox"/> dental appliances |
| <input type="checkbox"/> knocked unconscious | | |

If yes to any of the above, please describe _____
