

NEW PATIENT INFORMATION

Date: _____

First Name _____ Middle Initial _____ Last Name _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____ May We Send You Our Practice Newsletter? _____

Date of Birth: ____/____/____ Age: _____ Employer: _____

Marital Status: Married / Single / Divorced / Widow Number of Children: _____

Emergency Contact : _____ Contact Phone: _____

Family Physician: _____ Phone Number: _____

How did you hear about our office? _____

1. What are the complaints for which you are seeking treatment?

2. If you have pain, please describe and give location: _____

3. How often do you experience your symptoms?

Constantly (76-100% of the time)

Occasionally (26-50% of the time)

Frequently (51-75% of the time)

Intermittently (1-25% of the time)

4. How would you describe the type of pain?

Sharp

Numb

Dull

Tingly

Diffuse

Sharp with motion

Achy

Shooting with motion

Burning

Stabbing with motion

Shooting

Electric like with motion

Stiff

Other: _____

5. How are your symptoms changing with time?

Getting Worse

Staying the Same

Getting Better

Name _____

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

Not at all A little bit Moderately Quite a bit Extremely

8. How much has the problem interfered with your social activities?

Not at all A little bit Moderately Quite a bit Extremely

9. Who else have you seen for your problem?

Chiropractor Neurologist Primary Care Physician
 ER physician Orthopedist Other: _____
 Massage Therapist Physical Therapist No one

10. How long have you had this problem? _____

11. How do you think your problem began? _____

12. Do you consider this problem to be severe?

Yes Yes, at times No

13. What aggravates your problem?

14. What concerns you the most about your problem; what does it prevent you from doing?

15. What is your: Height _____ Weight _____ Date of Birth _____

Occupation _____

16. How would you rate your overall Health?

Excellent Very Good Good Fair Poor

17. What type of exercise do you do?

Strenuous Moderate Light None

18. Indicate if you have any immediate family members with any of the following:

Rheumatoid Arthritis Diabetes Lupus
 Heart Problems Cancer ALS Other

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination

Name _____

- | | | |
|---|--|--|
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Stroke | <input type="checkbox"/> Smoking/Tobacco Use |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Angina | <input type="checkbox"/> Drug/Alcohol Dependence |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Elbow/Upper Arm Pain | <input type="checkbox"/> Kidney Disorders | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Wrist Pain | <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> Systemic Lupus |
| <input type="checkbox"/> Hand Pain | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Loss of Bladder Control | <input type="checkbox"/> Dermatitis/Eczema/Rash |
| <input type="checkbox"/> Upper Leg Pain | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Abnormal Weight Gain/Loss | |
| <input type="checkbox"/> Ankle/Foot Pain | <input type="checkbox"/> Loss of Appetite | For Females Only |
| <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Birth Control Pills |
| <input type="checkbox"/> Joint Pain/Stiffness | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Hormonal Replacement |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Liver/Gall Bladder Disorder | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> General Fatigue | |
| <input type="checkbox"/> Tumor | <input type="checkbox"/> Muscular Incoordination | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Visual Disturbances | |
| <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Other: _____ |

20. List all prescription medications you are currently taking:

21. List all of the vitamins/supplements you are currently taking:

22. List all surgical procedures you have had:

23. What activities do you do at work?

- | | | | |
|---|--|---------------------------------------|--|
| <input type="checkbox"/> Sit: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |

24. What activities do you enjoy outside of work?

25. Have you ever been hospitalized? No Yes

if yes, why _____

26. Have you ever been treated by a chiropractor? No Yes

If so, explain when/why: _____

26. Have you had significant past trauma? No Yes _____

27. Anything else pertinent to your visit today? _____