

# NEW PATIENT INFORMATION

## PERSONAL INFORMATION:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Daytime Phone #: \_\_\_\_\_  
Other Phone #(s): \_\_\_\_\_  
Date Of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Age: \_\_\_\_\_ Gender: *male / female*  
Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Marital Status: *minor / single / engaged / married /  
legally separated / divorced / widowed*

If Minor, Parent / Guardian: \_\_\_\_\_  
Spouse / Significant Other: \_\_\_\_\_  
If Children, Names & Ages: \_\_\_\_\_

Any Special Circumstances: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Phone #(s): \_\_\_\_\_

## OCCUPATIONAL INFORMATION:

Employment Status: *full-time / part-time / retired  
stay-at-home / unemployed / student*  
Place Of Employment: \_\_\_\_\_  
Occupation / Title: \_\_\_\_\_

At Work, Do You..... (check all that apply)

<input type="checkbox"/> frequently sit	<input type="checkbox"/> frequently stand
<input type="checkbox"/> do repetitious tasks	<input type="checkbox"/> bend / stoop
<input type="checkbox"/> light / heavy lifting	<input type="checkbox"/> light / heavy labor
<input type="checkbox"/> use computers	<input type="checkbox"/> other: _____

## FINANCIAL INFORMATION:

Person Responsible For Payment: \_\_\_\_\_  
Payment By: *cash / check / credit card / insurance*

*If paying by insurance, please take your insurance card to the front desk to copy. If you do not have a card, please ask for the proper forms to fill out.*

## PRESENT HISTORY:

Rate Your Health: *excellent / fair / poor*  
Rate Your Diet: *excellent / fair / poor*  
Amount Of Exercise: *regular / irregular / none*  
Rate Your Stress Level On The 1-10 Scale (10 = High)  
At Home: \_\_\_\_\_ At Work: \_\_\_\_\_  
Do You Use Any Of The Following? Amount / Day?  
Tobacco: \_\_\_\_\_  
Alcohol: \_\_\_\_\_  
Caffeine: \_\_\_\_\_  
Are You Under Medical Care Now? *yes / no*  
If So, For What? \_\_\_\_\_  
Doctor's Name: \_\_\_\_\_  
Last Physical Exam Date: \_\_\_\_\_  
Prescription Drugs? \_\_\_\_\_  
Over-the-Counter Drugs? \_\_\_\_\_  
Supplements? \_\_\_\_\_

Amount Of Sleep Per Night: \_\_\_\_\_

I Sleep On My: *back / right side / left side / stomach*

Please Check All That Apply.....

<input type="checkbox"/> I sleep on my stomach.
<input type="checkbox"/> I sleep with my arms over my head.
<input type="checkbox"/> I sleep in the fetal position. (curled up)
<input type="checkbox"/> I sleep twisted. (½ side & ½ back / stomach)
<input type="checkbox"/> I use more than 1 pillow under my head.
<input type="checkbox"/> I use a waterbed / very soft mattress.
<input type="checkbox"/> I sit with my wallet in my back pocket.
<input type="checkbox"/> I cross my legs when I sit.
<input type="checkbox"/> I hold the phone with my neck.
<input type="checkbox"/> I carry a purse / bag / child usually on one side.
<input type="checkbox"/> I pop / crack my neck, back or other joints.

Females: Could You Be Pregnant? *yes / no*

Date of Last Menstrual Period: \_\_\_\_\_

If yes, Estimated Due Date: \_\_\_\_\_

Midwife / ObGyn: \_\_\_\_\_

## PAST HISTORY:

Please Check All That Apply & Explain.....

<input type="checkbox"/> Fractures: _____
<input type="checkbox"/> Dislocations: _____
<input type="checkbox"/> Head Injuries: _____
<input type="checkbox"/> Falls / Injuries: _____
<input type="checkbox"/> Car Accidents: _____
<input type="checkbox"/> Surgeries: _____
<input type="checkbox"/> Hospitalizations: _____
<input type="checkbox"/> Stroke / Heart Attack: _____
<input type="checkbox"/> Seizures / Black Outs: _____
<input type="checkbox"/> Allergies / Asthma: _____

Please List All Medical Conditions: \_\_\_\_\_

Significant Family History: *cancer / heart disease /  
stroke / diabetes / epilepsy / thyroid conditions /  
bleeding disorders / arthritis / allergies / asthma /  
other: \_\_\_\_\_*

Do You Wear A Prosthesis / Pacemaker? *yes / no*

Do You Wear Lifts / Arch Supports? *yes / no*

Have You Had Chiropractic Care Before? *yes / no*

If Yes, When Was Your Last Visit? \_\_\_\_\_

Date Of Most Recent X-rays? \_\_\_\_\_

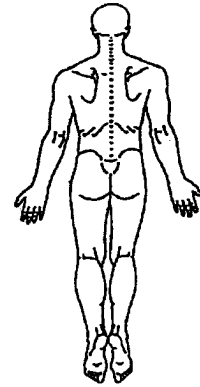
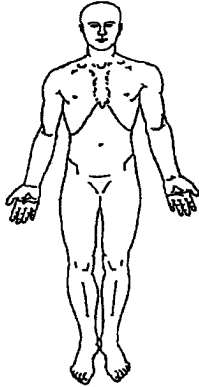
**REASON FOR VISIT:**

Are You Here For Wellness Care OR For Treatment Of A Specific Problem? \_\_\_\_\_

Please Use The Diagrams Below To Indicate The Problem(s) You Are Having: *(skip this section if no problems)*

Circle The Location & Use These Abbreviations For Descriptors:

- A = Ache
- BP = Burning Pain
- C = Cramp
- D = Dull Pain / Soreness
- N = Numbness
- PNS = Pins & Needles Sensation
- S = Stiffness
- SSP = Sharp / Stabbing Pain
- T = Throbbing
- TSP = Traveling / Shooting Pain
- O = Other



When Did The Problem Begin? \_\_\_\_\_ Have You Had This Before? *yes / no*

How Did It Start..... \_\_\_\_\_ It Came On Gradually \_\_\_\_\_ It Happened Suddenly \_\_\_\_\_ Unsure

What Were You Doing When You First Noticed The Problem? \_\_\_\_\_

Is The Problem Due To An Auto Or Work -Related Injury? *yes / no (if yes, please ask for the proper forms)*

Since The Problem Began, Is It..... \_\_\_\_\_ Getting Better \_\_\_\_\_ Getting Worse \_\_\_\_\_ Staying The Same

How Frequent Is Your Problem? \_\_\_\_\_ It Comes & Goes \_\_\_\_\_ It's Constant \_\_\_\_\_ Other: \_\_\_\_\_

Would You Say It Is Worse In The..... \_\_\_\_\_ Mornings \_\_\_\_\_ Afternoons \_\_\_\_\_ Evenings

Does Your Problem Vary In Intensity? *yes / no (if yes, in the question below- give rates for those variations)*

Rate Any Pain On A Scale Of 1-10 (1 = Minimal & 10 = Worst Pain Ever): \_\_\_\_\_

What Things Make The Problem Worse? \_\_\_\_\_

What Things Make The Problem Better? \_\_\_\_\_

Does This Problem Interfere With..... \_\_\_\_\_ Work \_\_\_\_\_ Sleep \_\_\_\_\_ Daily Routine \_\_\_\_\_ Other

Have You Noticed Any Bodily Changes Since It Began? *yes / no; If So, What?* \_\_\_\_\_

What Have You Done To Try & Help The Problem & What Were The Results? \_\_\_\_\_

What Other Specialists Have You Consulted With For This Problem? \_\_\_\_\_

**TO SERVE YOU BETTER:**

*Your health affects everything you do & everyone you know. That's why our mission at Westside Chiropractic Center, is to aid in the restoration of health by providing quality care through chiropractic, nutrition, massage & rehabilitation; so that our patients can achieve & maintain optimum health. We welcome the opportunity to help in your road back to health. Answering the questions on this form will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.*

Which Type Of Care Are You Interested In: (please check all that apply)

\_\_\_\_\_ Relief & Stabilization Care: *elimination of symptoms through chiropractic adjustments & possibly therapies*

\_\_\_\_\_ Rehabilitative & Reconstructive Care: *healing & prevention through exercise, nutrition & stressor identification*

\_\_\_\_\_ Maintenance & Wellness Care: *reaching your full potential & keeping you symptom free through regular check-ups*

Please Indicate Which Preference You Have For Your Chiropractic Adjustments:

\_\_\_\_\_ manual (with hands) \_\_\_\_\_ instrument (Activator) \_\_\_\_\_ no preference / unsure

Please List Any Health Goals You Have: \_\_\_\_\_

How Did You Find Out About Our Clinic?

\_\_\_\_\_ Yellow Pages \_\_\_\_\_ Website \_\_\_\_\_ Advertisement \_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_ Referral: \_\_\_\_\_

*The statements made on this form are accurate to the best of my recollection & I have left nothing out.*

signature

date