

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:

Place Of Employment: _____
Occupation / Title: _____
Primary Work Activities: _____

At Work, Do You..... (check all that apply)
_____ frequently sit _____ frequently stand
_____ do repetitious tasks _____ bend / stoop
_____ do light / heavy lifting _____ do light / heavy labor
_____ use computers _____ 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? _____
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.....
_____ I sleep on my stomach.
_____ I sleep with my arms over my head.
_____ I sleep in the fetal position. (curled up)
_____ I sleep twisted. ($\frac{1}{2}$ side & $\frac{1}{2}$ back / stomach)
_____ I use more than 1 pillow under my head.
_____ I use a waterbed / very soft mattress.
_____ I sit with my wallet in my back pocket.
_____ I cross my legs when I sit.
_____ I hold the phone with my neck.
_____ I carry a purse / bag / child usually on one side.
_____ I pop / crack my neck, back or other joints.
Females: Could You Be Pregnant? *yes / no*
Date of Last Menstrual Period: _____

PAST HISTORY:

Please Check All That Apply & Explain.....
_____ Fractures: _____
_____ Dislocations: _____
_____ Head Injuries: _____
_____ Falls / Injuries: _____
_____ Car Accidents: _____
_____ Surgeries: _____
_____ Hospitalizations: _____
_____ Stroke / Heart Attack: _____
_____ Seizures / Black Outs: _____

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? *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? _____

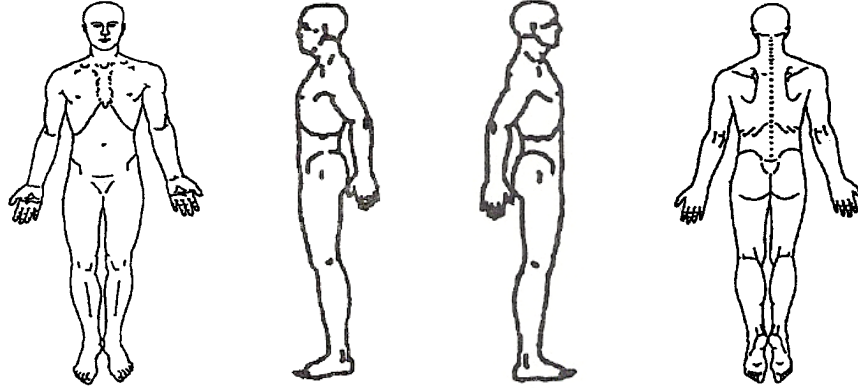
REASON FOR VISIT:

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
- 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*

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

Is Your Pain Constant? *yes / no* What Percentage Of The Day Is It Present? 25% / 50% / 75% / 100%

Rate Your 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 Doctors Have You Seen For This Problem? _____

TO SERVE YOU BETTER:

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the reason you came to our office, & second, to offer you the opportunity of improved health potential. 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

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