

New Patient Welcome To Our Office

Date _____

Name _____ Preferred name _____

Address _____

City/State/Zip _____

Phone #s (home) _____ (cell) _____

Email address _____

SS # _____ Birthdate _____ Age _____

Occupation _____ Employer _____

Is it okay to contact you at work? no yes Work # _____

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):

Favorite hobbies or interests _____

Emergency contact: Name _____

Relationship _____ Phone #(s) _____

What Brings You Here?

Have you ever had chiropractic care before? no yes

If yes, please tell us who _____ Phone # _____

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 pressing health concerns?:

For how long? _____

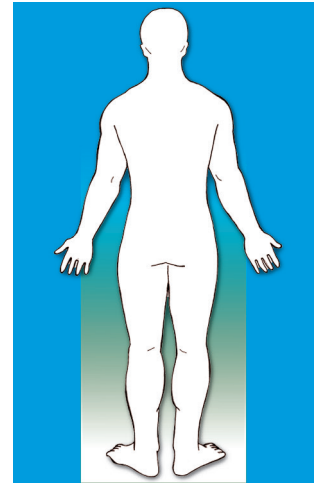
Is it getting worse improving intermittent constant can't say

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 affected by sitting standing walking
- bending lying down weather other

Please explain:

- Do you feel cramps burning stiffness swelling other

Please explain:

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

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 |
| <input type="checkbox"/> colitis | <input type="checkbox"/> stroke | <input type="checkbox"/> allergies | _____ | |

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

Do you drink coffee tea alcohol

Do you use cigarettes recreational drugs artificial sweeteners sugar

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

- | | | |
|--|---|---|
| <input type="checkbox"/> neck pain | <input type="checkbox"/> difficulty breathing | <input type="checkbox"/> discolored urine |
| <input type="checkbox"/> low back pain | <input type="checkbox"/> stuffy nose | <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"/> irritable bowel |
| <input type="checkbox"/> arm pain/tingling | <input type="checkbox"/> poor appetite | <input type="checkbox"/> black or bloody stools |
| <input type="checkbox"/> shoulder pain | <input type="checkbox"/> excessive appetite | <input type="checkbox"/> constipation |
| <input type="checkbox"/> hand pain/tingling | <input type="checkbox"/> nervousness | <input type="checkbox"/> hemorrhoids |
| <input type="checkbox"/> leg pain/tingling | <input type="checkbox"/> confusion | <input type="checkbox"/> liver problems |
| <input type="checkbox"/> jaw pain | <input type="checkbox"/> depression | <input type="checkbox"/> paralysis |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> dental problems | <input type="checkbox"/> numbness |
| <input type="checkbox"/> lung problems | <input type="checkbox"/> excessive thirst | <input type="checkbox"/> fatigue |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> frequent nausea | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> abnormal blood pressure | <input type="checkbox"/> prostate problem | <input type="checkbox"/> loss of sleep |
| <input type="checkbox"/> irregular heartbeat | <input type="checkbox"/> breast pain/lump | <input type="checkbox"/> difficulty hearing |
| <input type="checkbox"/> ankle swelling | <input type="checkbox"/> cramps | <input type="checkbox"/> ear pain |
| <input type="checkbox"/> cold extremities | <input type="checkbox"/> painful urination | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> blurred vision | <input type="checkbox"/> bladder trouble | |
| <input type="checkbox"/> vision problems | <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"/> surgery |
| <input type="checkbox"/> sports injuries | <input type="checkbox"/> broken bones | <input type="checkbox"/> dislocations | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> spinal tap | <input type="checkbox"/> knocked unconscious | <input type="checkbox"/> traction | _____ |
| <input type="checkbox"/> use(d) a cane or walker | <input type="checkbox"/> extensive dental work | <input type="checkbox"/> dental applications | _____ |

If yes to any of the above, please describe:

What Do You Know About Chiropractic?

In your own words, what do chiropractors do?:

Do you know what a subluxation is? no yes

If yes, please describe:

Do any friends or relatives see chiropractors: no yes

If yes, do they use chiropractic for health maintenance/optimization

health problems both

Are you seeking chiropractic for

health maintenance/optimization

health problems both

What would you like to gain from chiropractic care?:

Are there other health concerns or anything else you'd like us to know about you? no yes

If yes, please tell us:

Financial Responsibility

Who is responsible for payment? _____

How will you pay for your care? Cash Check Credit Card

Credit card # _____ Exp. _____

Insurance co. _____ Phone # _____

ID # _____ Group # _____

Subscribers's name _____ Phone # _____

Relation _____ Subscriber's employer _____

Subscribers's SS # _____ Subscriber's birthdate _____

The above is accurate to the best of my knowledge.

(signature)

(date)

I, parent/guardian, give permission for minor's care.

(signature)

(date)