New Patient Information

Full Name ____ Date ________________

Name you go by (Nickname) ____

Address ______________________________ City _____________ State _____ Zip ________

Date of Birth ____________ Home Phone _____________Best time to call ______________

Employer _________________ Work Phone _______________ Occupation _____________

Address ______________________________ City _____________ State _____ Zip ________

Number of Children ________ Ages of Children ___________ Referred By ________________

Email:______________________ Name of Spouse/Partner __________________________

Name & Phone of person to contact if we cannot reach you ______________________________

The practice of chiropractic is based upon the location and adjustment of vertebral subluxations. These spinal subluxations are caused by any stress to which your body cannot adapt. These stresses may by **physical**, **chemical**, or **emotional** in nature.

Health Information

What brings you to our office today?____

When did this condition begin? __________________________ Have you had it before? ____Yes _____No

Is this condition getting worse? ____Yes _____No How do you rate the pain 1 (least) to 10 (severe)? ________

Type of pain (circle): Achy Tight Tense Sharp Stiff Stabbing Throbbing Burning Tingling Numb Dull

Nature of the pain (circle): Constant Frequent Intermittent Episodic

What makes the pain better? ____

What makes the pain worse? ____

Does your pain interfere with (circle): Work Sleep Recreation Activities of Daily Living Everyday Life

Have you seen anyone for this condition? ________ Who/Results? ___________________________

Is this condition job or auto accident related? ______________________________________

List any other complaints/pain? ____

Supplements currently taking? ____

Medication(s) currently taking? For What?____

How do you rate your physical health? ________ Excellent________Good ________Fair ______Poor

Do you exercise regularly? If so, how often? ____

Do you have any chronic illnesses? ____

List any surgeries you have had ______________________________

List any accidents/injuries/broken bones______________________________

Do you have any congenital disorders? ______________________________

Did you have any childhood illnesses or injuries? ______________________________

Lifestyle and Habits - Please list amounts of each

Coffee/Caffeine ____________ Alcohol ____________ Non-caffeinated fluids/Water ____________

Tobacco ____________ Exercise ____________ Sleep ____________

Have you ever received Chiropractic care? ___Y ___N Doctor: ____________ Location: ____________

Approximately how long were you under care? ____________ Date of last visit? ____________

Why did you stop? ______________________________

Mothers - Previous Pregnancies/Births

Did you have chiropractic care during any previous pregnancies? _____Y _____N

# of previous pregnancies: ____________ # of previous births ____________

Please explain any discrepancy: ______________________________

Names & ages of children: ______________________________

Your previous births were at: Hospital ____________ Home ____________ Birth Center ____________

Medications used in prior births: None ____________ Ptocin ____________ Epidural ____________

Interventions used in prior births: Breaking of water ________ Vacuum ________ Forceps ________ Episiotomy _______

How long was your previous labor? Total: ____________ Time before you pushed: ____________

Time you spent pushing: ______________________________

Any additional information. ______________________________

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Additional Information

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______________________________ Patient Signature

______________________________ Doctor Signature

Confidential Health History

The following items may relate to your current condition. In the space in front of each item, place a P if you PRESENTLY have the problem and an H if you previously HAD the problem. Leave space blank if you NEVER had the problem.

GENERAL
_____ Anemia
_____ Allergies
_____ Bleeding Problem
_____ Cancer/Tumors
_____ Diabetes
_____ Epilepsy
_____ Fainting or Seizures
_____ Fibromyalgia
_____ Gout
_____ Hepatitis
_____ High Cholesterol
_____ Loss of Sleep
_____ Multiple Sclerosis
_____ Night Sweats
_____ Osteoporosis
_____ Tiredness
_____ Thyroid Problems
_____ Weight Loss or Gain

CARDIOVASCULAR
_____ Chest Pain
_____ Heart Disease
_____ High Blood Pressure
_____ Irregular Heartbeat
_____ Low Blood Pressure
_____ Pacemaker
_____ Poor Circulation
_____ Stroke
_____ Swelling of Ankles
_____ Varicose Veins
_____ Heart/Lung Defect

RESPIRATORY
_____ Asthma
_____ Difficult Breathing
_____ Chronic Cough
_____ COPD
_____ Emphysema
_____ Pneumonia
_____ Tuberculosis
_____ Wheezing

MUSCULOSKELETAL
_____ Spinal Curvature
_____ Arthritis

GENITO-URINARY
_____ Bladder Trouble
_____ Difficulty Starting/Stopping Flow
_____ Frequent Urination
_____ Painful Urination

GASTROINTESTINAL
_____ Poor Appetite
_____ Black or Bloody Stools
_____ Bloating/Gas
_____ Colitis/IBS
_____ Constipation
_____ Diarrhea
_____ Excessive Hunger or Thirst
_____ Hemorrhoids
_____ Hernia
_____ Indigestion
_____ Liver Disease
_____ Loss of Bowel Control
_____ Nausea
_____ Reflux
_____ Stomach Pain
_____ Liver Problems
_____ Ulcer
_____ Vomiting

WOMEN ONLY
_____ Abnormal Periods
_____ Dysmenorrhea
_____ Endometriosis
_____ Extreme Cramps
_____ Hot Flashes
Date of Last Period ________
Last Mammogram _________
Last Pap Smear ____________

HABITS
_____ Coffee/Caffeine Cups/day
_____ High Stress Level

NEUROLOGIC/MENTAL
_____ Anxiety
_____ Anger/Aggression
_____ Attention Deficit
_____ Psychotic episodes
_____ Tremors
_____ Mental Disorder

FAMILY HISTORY
_____ Cancer
_____ Diabetes
_____ Heart Disease
_____ High Blood Pressure
_____ Kidney Disease
_____ Muscle, Bone or Nerve Disease
_____ Thyroid Disease/Goiter
_____ Tuberculosis
_____ Other