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 _____

Marital Status: S M D W Sep Name of Spouse/Partner _____

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

Email_____

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 currently taking? For What?_____

How do you rate your physical health? _____ Excellent_____Good _____Fair _____Poor

Do you exercise regularly? _____

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? _____

Pregnancy History

Were there any difficulties or irregularities of your menses prior? _____

Were there any difficulties getting pregnant? _____

Due Date/Week _____ I am in my: _____ week of pregnancy.

Pre-pregnancy weight _____ Current Weight _____ Height _____

Childbirth caregiver(s): OB/GYN _____ Doula _____ Midwife _____

Last visit to caregiver_____ Caregiver name & phone # _____

I plan on giving birth at: Hospital _____ Home _____ Birth Center _____

Name of Hospital or Birth Center _____

Any Ultrasounds performed? If Yes, How Many?_____

Any traumas during this pregnancy? If yes, please describe: _____

_____

Any hospitalizations during this pregnancy? If yes, please describe:_____

_____

Any medications during this pregnancy, including over the counter medication? Please describe: _____

_____

Any fertility treatment? If yes, please describe:_____

_____

Any other information about your pregnancy? _____

_____

After 32 Weeks

Position of baby: Head down_____ Posterior_____ Breech or malpositioned_____

Confirmed by: _____ Location:_____

Palpation by: _____ Date: _____

Ultrasound by:_____ Date:_____

How long do you believe baby has been in this position?_____

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. _____

_____

_____

Additional Information

_____

_____

_____

_____

_____

_____ _____

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