

Patient \_\_\_\_\_  
 Doctor \_\_\_\_\_  
 Date \_\_\_\_\_ Case # \_\_\_\_\_

New Patient

## Welcome To Our Office



Name \_\_\_\_\_ Preferred name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone #s (home) \_\_\_\_\_ (cell) \_\_\_\_\_

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

E-mail address \_\_\_\_\_ Web site \_\_\_\_\_

SS# \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

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) \_\_\_\_\_

Emergency contact: Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone #(s) \_\_\_\_\_

Favorite hobbies or interests \_\_\_\_\_

### What Brings You Here?

Have you ever had chiropractic care before?  no  yes

If yes, please tell us the doctor's name \_\_\_\_\_

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 most 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  sitting  standing  walking  
affected by  bending  lying down  weather

Please explain \_\_\_\_\_

Do you feel  cramps  burning  other  
 swelling  stiffness \_\_\_\_\_

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

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   |

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

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- Do you use
- |                                  |                                     |  |                                |
|----------------------------------|-------------------------------------|--|--------------------------------|
| <input type="checkbox"/> coffee  | <input type="checkbox"/> tea        | <input type="checkbox"/> artificial sweeteners | <input type="checkbox"/> sugar |
| <input type="checkbox"/> alcohol | <input type="checkbox"/> cigarettes | <input type="checkbox"/> recreational drugs    |                                |

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

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

If yes to any of the above, please describe \_\_\_\_\_

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