

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? _____

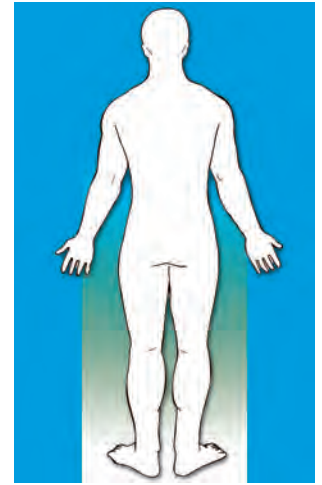
For how long? _____

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)