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CHIROPRACTIC NEW PATIENT FORM

Name: ______________________________ Date: ______________

Home/Cell Phone: ______________________ Work Phone: ______________

Address: ______________________________ City: ______________

State: __________ Zip Code: __________ Date of Birth: ______________

Occupation: ______________________ Number of children and ages: ____________

Circle Please: Married Single Widowed Divorced Separated

Name of Spouse: ______________________ Occupation: ______________

Referred to Our Office By: ______________________________

Reason for Visit: ______________________________

Other Doctors Seen for this condition: YES NO Who? ______________________

Type of treatment: ______________________ Results: ______________

When did this condition begin? ______________________ Has it happened before? __________

Is this condition: Job Related Auto Accident Home Injury Fall Other: ______________

WHEN and HOW did this condition develop? ______________________________

____

Describe the pain/discomfort: (sharp, shooting, piercing, burning, aching, etc)______________

What makes it feel better? ______________________________

What makes it feel worse? ______________________________

Does the pain/discomfort stay in one area? YES/NO Is the pain/discomfort the same throughout the day? YES/NO

Is it better in the mornings? YES/NO Better in the evenings? YES/NO Better in the middle of the day? YES/NO

How has this condition affected your life? (Home, Work, Play, Sleep)______________________

____

Do you suffer from any conditions other than that which you are consulting us? If yes, please explain: ______________

____

Are you taking any medications or supplements? Please list: ______________________

____

Have you ever been in an automobile accident? Never Past Year Past 5 Years Over 5 Years

Any hospitalizations or surgeries? YES/NO ______________________________

Please Circle "P" for Past, "C" for Current, or leave blank if not applicable.

General

1 P / C Fever
2 P / C Chills
3 P / C Night Sweats
4 P / C Loss of Sleep
5 P / C Fatigue
6 P / C Nervousness
7 P / C Weight Gain/Loss
8 P / C Allergies
9 P / C Bleeding Problems
10 P / C Anemia
11 P / C Diabetes
12 P / C Thyroid Disease/Goiter
13 P / C Alcoholism
14 P / C Drug Abuse

Eyes/Ears/Nose/Throat

15 P / C Poor Vision
16 P / C Pain in Eye(s)
17 P / C Deafness/Difficulty Hearing
18 P / C Nosebleeds
19 P / C Nose Problems
20 P / C Sinus Trouble
21 P / C Dental Problems
22 P / C Hoarseness
23 P / C Tonsillectomy

Gastrointestinal

24 P / C Poor Appetite
25 P / C Poor Digestion
26 P / C Difficulty Swallowing
27 P / C Belching or Gas
28 P / C Frequent Nausea
29 P / C Vomiting
30 P / C Vomiting Blood
31 P / C Pain over Abdomen
32 P / C Ulcer
33 P / C Black or Bloody Stools
34 P / C Liver Problems
35 P / C Gall Bladder Problems
36 P / C Jaundice
37 P / C Hernia
38 P / C Diarrhea
39 P / C Constipation
40 P / C Hemorrhoids
41 P / C Appendicitis

Men Only

42 P / C Testicular Swelling/Pain
43 P / C Prostate Problems

Respiratory

44 P / C Difficulty Breathing
45 P / C Chronic Cough
46 P / C Spitting Phelgm
47 P / C Spitting Blood
48 P / C Wheezing/Asthma
49 P / C Pheumonia
50 P / C Tuberculosis

Cardiovascular

51 P / C Irregular Heartbeat
52 P / C High Blood Pressure
53 P / C Pain over Heart
54 P / C Previous Heart Trouble
55 P / C Ankle Swelling
56 P / C Varicose Veins
57 P / C Rheumatic Fever
58 P / C Stroke

Genitourinary

59 P / C Frequent Urination
60 P / C Painful Urination
61 P / C Blood in Urine
62 P / C Kidney Disease
63 P / C Urinary Infection
64 P / C Inability to Control Urination
65 P / C Difficulty Starting Urine Flow
66 P / C Get up___ times/night to urinate
67 P / C Breast Lump/Pain
68 P / C Venereal Infection
69 P / C Sexual Difficulties

Skin

70 P / C Itching
71 P / C Bruising Easily
72 P / C Changes in Mole(s)
73 P / C Skin Cancer

Women Only

74 P / C Painful Periods
75 P / C Excessive Flow
76 P / C Irregular Cycles
77 P / C Vaginal Buring/Itching
78 P / C Hot Flashes
79 ________ Date of Last Period
80 ________ Date of Last PAP Test

81 ________ Last Eye Exam
82 ________ Last Dental Exam

Neurologic

83 P / C Weakness
84 P / C Twitching
85 P / C Tremors
86 P / C Headache
87 P / C Fainting
88 P / C Dizziness
89 P / C convulsions
90 P / C Epilepsy
91 P / C Numbness/Tingling
92 P / C Arm/Leg Pain
93 P / C Mental Disorder

Habits

94 P / C Smoking
________Packs/day
95 P / C Drinking
96 P / C Recreational Drugs

Musculoskeletal

97 P / C Neck Stiffness/Pain
98 P / C Pain Between Shoulders
99 P / C Low Back Pain
100 P / C Swollen Joints
101 P / C Painful Joints
102 P / C Muscle Aches/Soreness
103 P / C Spinal Curvature
104 P / C Arthritis

Exercise

105 P / C None
106 P / C 1-2 times/week
107 P / C 3-5 times/week
108 P / C 6-7 times/week

Family History

Include Information on brothers, sisters, parents grandparents, etc.
Do NOT Include Yourself

109 P / C Diabetes
110 P / C Thyroid Disease/Goiter
111 P / C Tuberculosis
112 P / C Kidney Disease
113 P / C Heart Disease
114 P / C Cancer
115 P / C Muscle, Bone, Nerve Disease