NEW PATIENT FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Patient Information:

Name: _____

(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____

(Last) (First) (Middle Initial)

Home Phone: (_____)_____ May we leave a message? □Yes □No

Cell/Other Phone: (_____)_____ May we leave a message? □Yes □No

E-mail: _____ May we email you? □Yes □No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Address: _____
Street Address

_____
City State Zip

How long have you been living at this address? _____

Employer: _____

Occupation: _____

Social Security Number: _____

Date of Birth: _____ Sex: □ Male □Female

Height: _____ Weight: _____

Marital Status:
□ Never Married □ Married □ Domestic Partnership □ Divorced □ Widowed

Referred by (if any): _____

Emergency Contact Information:

Name: _____

Relation: _____

Emergency Phone: _____

Reason for Visit:

My injury is related to:
□ Work □ Sports □ Auto □ Trauma □ Chronic

Please describe: _____
_____
_____

Please briefly describe where you feel the pain, its location, and the kind of pain it is:___
_____
_____

When did the pain or discomfort begin?_____

Is the condition getting worse? □ Yes □ No □ Constant □ Comes and Goes

Is the pain getting in the way of your: □ Work □ Sleep □ Daily Life
If yes, please describe how it interferes:_____
_____

Have you seen a Medical Physician for your pain? □ Yes □ No
If yes, please list who and where:_____
_____

Have you ever visited a Chiropractor before? □ Yes □ No
If yes, please list who and where:_____
_____

Who is your Primary Medical Care
Physician?_____

Phone Number:_____

Health History:

Have you ever had or suffered from any of the following:

Allergies	□Yes	□No
Asthma	□Yes	□No
AIDS/HIV	□Yes	□No
High Blood Pressure	□Yes	□No
Thyroid Problems	□Yes	□No
Respiratory Problems	□Yes	□No
Kidney Trouble	□Yes	□No
Migraines	□Yes	□No
Chronic cough	□Yes	□No
Coughing up blood	□Yes	□No
Low Blood Sugar	□Yes	□No
Epilepsy or Neurological Problems	□Yes	□No
Cancer	□Yes	□No
Sinus Trouble	□Yes	□No
Fainting Spells	□Yes	□No
Diabetes	□Yes	□No
Hepatitis/Jaundice/Liver Problems	□Yes	□No
Stomach Problems	□Yes	□No
Tuberculosis	□Yes	□No
Sexually Transmitted Disease	□Yes	□No
Mental Health Problem	□Yes	□No
Immune System Problems	□Yes	□No
Congestive Heart Failure	□Yes	□No
High Cholesterol	□Yes	□No
Heart Disease	□Yes	□No
Thyroid Disease	□Yes	□No
Stroke	□Yes	□No
Arthritis	□Yes	□No
COPD	□Yes	□No

Do you have any allergies to:

Anesthesia	□Yes	□No
Sulfa Drugs	□Yes	□No
Narcotics	□Yes	□No
Penicillin or Antibiotics	□Yes	□No
Barbiturates	□Yes	□No
Iodine	□Yes	□No
Other	□Yes	□No

If you have other allergies please describe:_____

_____

Hospitalizations:_____
_____
_____

Surgeries (Type and Date): _____
_____
_____

Medications:_____
_____
_____

Family Medical History

Please list all first-degree relatives who have experienced the following:

Heart Attack:_____
Stroke:_____
Diabetes:_____
High Blood Pressure:_____
Cancer:_____
Sudden Death:_____
Other:_____

Women Only

Date of your last menstrual period: _____ (mm/dd/yyyy)

Do your periods come every month? □ Yes □ No
If no, how often? _____

How long do your periods last? _____

Is your flow: □ Light □ Medium □ Heavy

Do you have pain or bleeding after sexual intercourse? □ Yes □ No

Have you been pregnant? □ Yes □ No
If yes, how many children do you have: _____

Are you currently taking birth control? □ Yes □ No
If so, what kind:_____

Date of your last pap smear: _____ (mm/dd/yyyy)
Have you ever had an abnormal pap? □ Yes □ No

When was your last mammogram/breast exam: _____(mm/dd/yyyy)
Was it normal? □ Yes □ No

Do you do self breast examinations? □ Yes □ No

Social History

Do you exercise regularly? □ Yes □ No
If so, how often and what type: _____
_____

How would you rate your current physical health?
□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very Good

Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits?
□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very Good

Please list any specific sleep problems you are currently experiencing:

_____

Do you follow a particular diet? □ Yes □ No
If so, what type:_____

Do you use tobacco? □ Yes □ No
If so, how often:_____

Do you use alcohol? □ Yes □ No
If so, how often:_____

What hobbies do you enjoy:_____

Purpose of today's visit:_____

Review of Symptoms

Please check if you have had any of the following in <u>past six months</u>:

Weight Loss or Gain	_____	Chest Pain	_____
Night Sweats	_____	Racing Heart	_____
Muscle Weakness	_____	Difficulty Breathing	_____
Skin Rashes	_____	Coughing	_____
Itching	_____	Seizures	_____
Dry Skin	_____	Dizziness	_____
Headaches	_____	Numbness	_____
Injuries	_____	Breast Pain	_____
Blurred Vision	_____	Nipple Discharge	_____
Ringing in Ears	_____	Disorientation	_____
Hearing Loss	_____	Loss/Increased Appetite	_____
Muscle Pain	_____	Nausea	_____
Runny Nose	_____	Vomiting	_____
Nose Bleed	_____	Diarrhea	_____
Joint Pain	_____	Constipation	_____
Cold Hands or Feet	_____	Indigestion	_____
Feeling Cold Often	_____	Excessive Sleeping	_____
Feeling Warm Often	_____	Difficulty Sleeping	_____
Sore Throat	_____	Anxiety	_____
Hoarseness	_____	Mood Swings	_____
Fatigue	_____	Depressed Mood	_____
Neck Stiffness	_____	Impotence	_____
Hair Loss/Growth	_____	Decreased Libido	_____