

New Patient Information

Date _____

Name _____ Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Work # _____ Cell # _____

E-mail address _____

Your employer _____ Your Position _____

Spouses/Partners Name _____ Ages of children _____

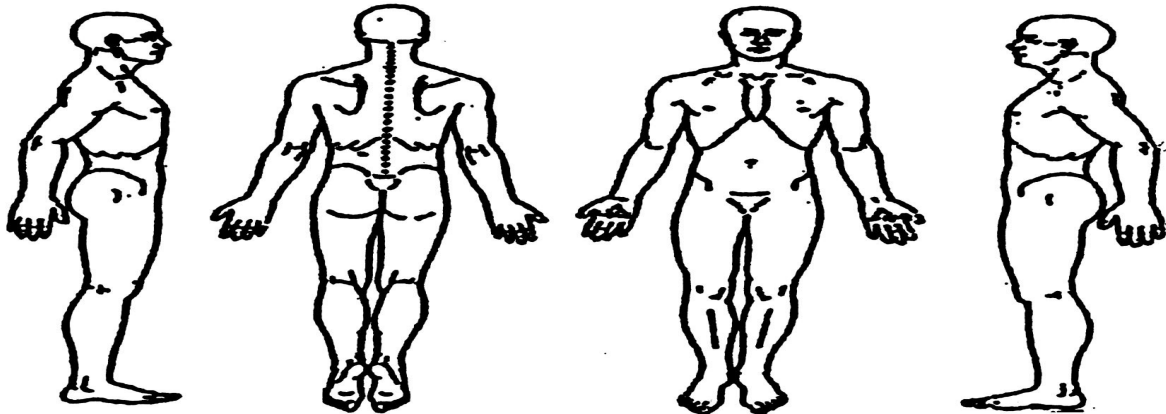
How will payment be made: Cash/Check Credit Card Health Insurance Auto Ins. Work Comp

Whom may we thank for referring you to our clinic? _____

Would you be interested in a complimentary nutrition consultation? (circle one) YES NO MAYBE

1. Is today's problem caused by: Auto Accident Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. Your MAIN complaint: (circle) Neck Mid- Back Lower Back Other _____

4. Using a scale from 0-10 (10 being the worst), how would you rate your MAIN Complaint?

0 1 2 3 4 5 6 7 8 9 10 (circle)

5. Your Secondary complaint: (circle) Neck Mid- Back Lower Back Other _____

6. Using a scale from 0-10 (10 being the worst), how would you rate your Secondary Complaint?

0 1 2 3 4 5 6 7 8 9 10 (circle)

7. How often do you experience your symptoms?

- | | |
|---|---|
| <input type="checkbox"/> Constantly (76-100% of the time) | <input type="checkbox"/> Occasionally (26-50% of the time) |
| <input type="checkbox"/> Frequently (51-75% of the time) | <input type="checkbox"/> Intermittently (1-25% of the time) |

8. How would you describe the type of pain?

- | | | | |
|-----------------------------------|---|----------------------------------|---|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Numb | <input type="checkbox"/> Achy | <input type="checkbox"/> Shooting with motion |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Tingly | <input type="checkbox"/> Burning | <input type="checkbox"/> Stabbing with motion |
| <input type="checkbox"/> Diffuse | <input type="checkbox"/> Sharp with motion | <input type="checkbox"/> Stiff | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Electric with motion | | |

9. How are your symptoms changing with time?

- Getting Worse Staying the Same Getting Better

10. How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

11. How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

12. Who else have you seen for your problem?

- Chiropractor Neurologist Primary Care Physician
 ER physician Orthopedist Other: _____
 Massage Therapist Physical Therapist No one

13. How long have you had this problem? _____

14. How do you think your problem began?

15. Do you consider this problem to be severe?

- Yes Yes, at times No

16. What aggravates your problem?

19. What concerns you the most about your problem; what does it prevent you from doing?

20. What is your: Height _____ Weight _____

21. How would you rate your overall Health?

- Excellent Very Good Good Fair Poor

22. What type of exercise do you do?

- Strenuous Moderate Light None

23. Indicate if you have any immediate family members with any of the following:

- Rheumatoid Arthritis Diabetes Lupus
 Heart Problems Cancer ALS

24. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Depression	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus

- | | | | | | |
|--------------------------|--|--------------------------|--|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Hand Pain | <input type="checkbox"/> | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> | <input type="checkbox"/> Loss of Bladder Control | <input type="checkbox"/> | <input type="checkbox"/> Dermatitis/Eczema/Rash |
| <input type="checkbox"/> | <input type="checkbox"/> Upper Leg Pain | <input type="checkbox"/> | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> | <input type="checkbox"/> Ulcer | <input type="checkbox"/> | <input type="checkbox"/> Muscular In-coordination |
| <input type="checkbox"/> | <input type="checkbox"/> Ankle/Foot Pain | <input type="checkbox"/> | <input type="checkbox"/> Loss of Appetite | For Females Only | |
| <input type="checkbox"/> | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> | <input type="checkbox"/> Birth Control Pills |
| <input type="checkbox"/> | <input type="checkbox"/> Joint Pain/Stiffness | <input type="checkbox"/> | <input type="checkbox"/> Tumor | <input type="checkbox"/> | <input type="checkbox"/> Hormonal Replacement |
| <input type="checkbox"/> | <input type="checkbox"/> Arthritis | <input type="checkbox"/> | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> | <input type="checkbox"/> Liver/Gall Bladder Disorder | | |
| <input type="checkbox"/> | <input type="checkbox"/> Cancer | <input type="checkbox"/> | <input type="checkbox"/> General Fatigue | | |
| <input type="checkbox"/> | <input type="checkbox"/> Abnormal Weight Gain/Loss | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> Asthma | <input type="checkbox"/> | <input type="checkbox"/> Visual Disturbances | | |
| <input type="checkbox"/> | <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> | <input type="checkbox"/> Dizziness | | |
| <input type="checkbox"/> | <input type="checkbox"/> Other: _____ | | | | |

25. List all prescription medications/over-the-counter medications you are currently taking:

26. List all of the nutritional supplements you are currently taking:

27. List all surgical procedures you have had:

28. What activities do you do at work?

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Sit: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |

29. What activities do you do outside of work?

30. Have you ever been hospitalized? No Yes

if yes, why _____

31. Have you had significant past trauma? No Yes

32. Have you had chiropractic care in the past? No Yes

Results _____

33. Anything else pertinent to your visit today?

Patient Signature _____ **Date:** _____