Patient Number: _____

New Patient Form

Patient Name _____ Date _____

Guardian Name (if under 18) _____

Street Address_____

City _____ State _____ Zip _____

Cell # _____ Home # _____

Email Address: _____

(Parent/Guardian if under 18)

Date of Birth _____/_____/_____ Age _____ Social Security #_____

How did you hear about the office? _____

Your Occupation _____

Who is your Referring Physician? _____ Phone # _____

Insurance Coverage

Name of Primary Insured (if Different) _____

Date of Birth of Primary Insured (if Different) ____/____/_____

Is your condition relevant to any of the following: ☐ Yes ☐ No

☐ Car accident ☐ Work injury ☐ Disability

Emergency Contact

Name _____Relationship _____

Contact # _____

NAME: _____

Medical History – Section 1

Medications ☐ Yes ☐ No If Yes, please list current medication

_____ _____

_____ _____

_____ _____

Surgeries ☐ Yes ☐ No If Yes, please list type and date

_____ _____

_____ _____

Past Accidents ☐ Yes ☐ No If Yes, please list type and date

_____ _____

_____ _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

_____

Family History

Disease:	Check Family Member(s) Attributed to Disease Relationship to You:					
Cancer:	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandmother	☐ Grandfather
Diabetes:	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandmother	☐ Grandfather
Heart Disease:	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandmother	☐ Grandfather
Stroke :	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandmother	☐ Grandfather

Other (Please List):_____

NAME: _____

Medical History – Section 2

1.	Do you wear a pacemaker?	YES	NO
2.	Do you have or have had any chest pain without physical activity?	YES	NO
3.	Have you ever been diagnosed with a heart condition?	YES	NO
4.	Do you feel pain in your chest when you do physical activity?	YES	NO
5.	Do you take prescribed drugs for blood pressure or a heart condition?	YES	NO
6.	Have you been advised by a doctor to avoid physical activity?	YES	NO
7.	Do you lose your balance due to dizziness or ever lose consciousness?	YES	NO
8.	Have you ever been diagnosed with cancer and/or had a tumor removed?	YES	NO
9.	Do you have a bone/joint problem that might worsen with physical activity?	YES	NO
10.	Have you had a recent hip or knee replacement? When? _____	YES	NO
11.	Do you have any of the following?		
	IUD coil_____ Metal pins_____ Metal bolts_____ Metal plates_____		NO
12.	Are you pregnant or have you given birth less than 6 weeks ago?	YES	NO
13.	Have you had a condition requiring medical attention in the past 8 weeks?	YES	NO
14.	Do you suffer from any of the following conditions?		
	Epilepsy_____ Diabetes_____ Severe migraine_____ Detached retina_____		NO
15.	Have you ever fractured any bones?	YES	NO
16.	Do you have any episodes of back pain or disc problems?	YES	NO
17.	Have you had any spinal surgeries?	YES	NO

I understand that these answers are relevant to my care and I have answered them truthfully and to the best of my ability.

Patient Name_____Guardian_____

Signature_____Date_____
(Signature of patient or legal guardian required if patient is younger than 18 years old)

NAME: _____

Medical History - Section 3

Height _____ Weight_____

Symptoms:

Please mark **P**, for in the **Past**, **C** for **Currently** have, **O** for **Occasionally** or **N** for **Never.**

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun.
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea or Constipation
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problem
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disability
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping
___ Ulcers	___ Heartburn	___ Heart Problem	___ High Blood Pressure
___ Low Blood Pressure	___ Asthma	___ Difficulty Breathing	___ Lung Problems
___ Kidney Trouble	___ Gall Bladder Trouble	___ Liver Trouble	___ Hepatitis (A,B,C)

NAME: _____

History of Complaint – Section 1

Please identify the condition(s) that brought you to this office: Primary: _____

Secondary: _____ Third: _____ Fourth: _____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by *circling the number*:

Primary or chief complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Second complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Third complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Fourth complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

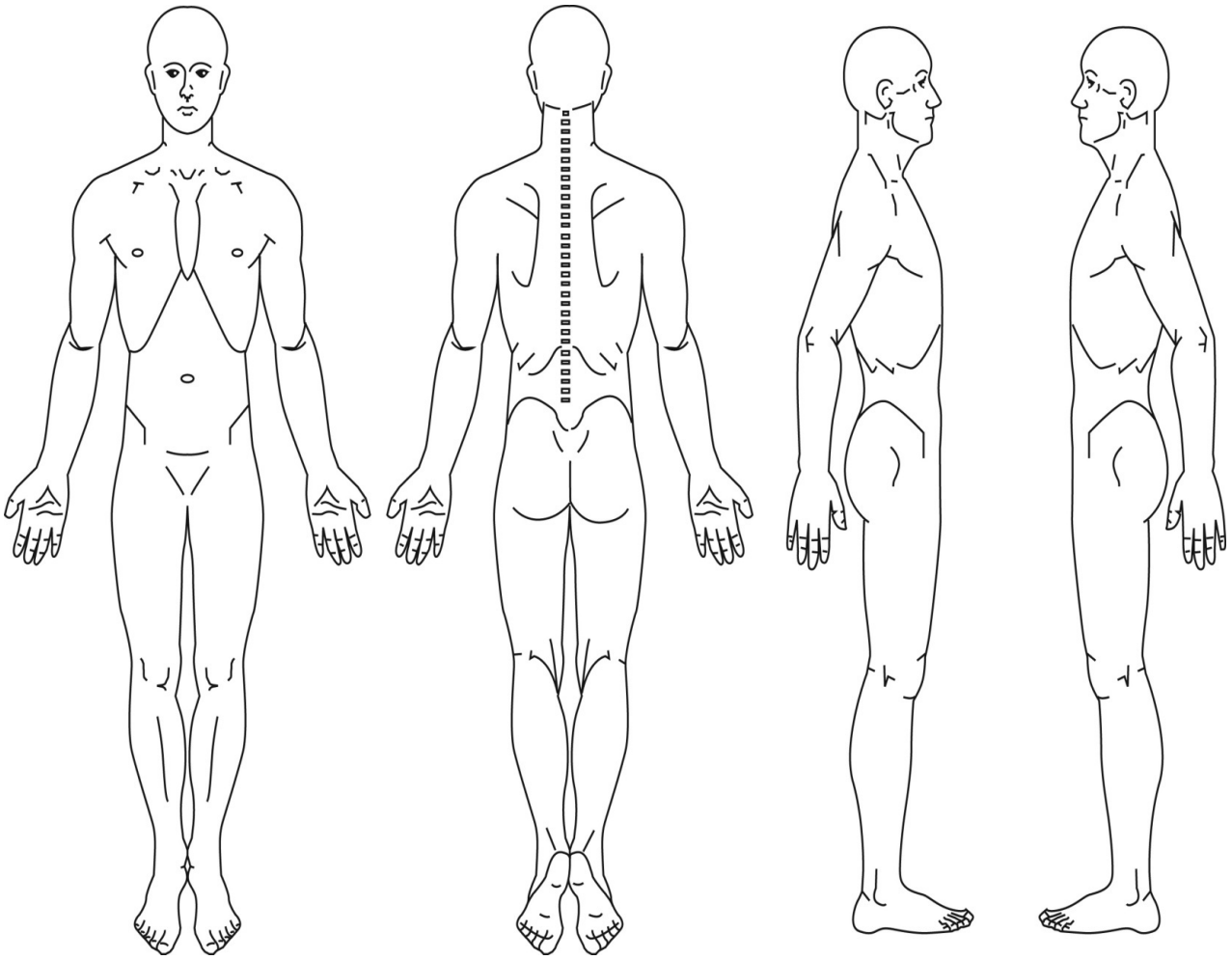
	Primary Complaint	**Secondary Complaint**	**Third Complaint**	**Fourth Complaint**
When did the problem(s) begin?				
When is the problem at its worst?	☐ AM ☐ PM ☐ mid-day ☐ late PM	☐ AM ☐ PM ☐ mid-day ☐ late PM	☐ AM ☐ PM ☐ mid-day ☐ late PM	☐ AM ☐ PM ☐ mid-day ☐ late PM
How long does it last?	☐ It is constant ☐ I experience it on and off during the day ☐ It comes and goes throughout the week	☐ It is constant ☐ I experience it on and off during the day ☐ It comes and goes throughout the week	☐ It is constant ☐ I experience it on and off during the day ☐ It comes and goes throughout the week	☐ It is constant ☐ I experience it on and off during the day ☐ It comes and goes throughout the week
How did the injury happen?				

NAME: _____

History of Complaint – Section 2

PLEASE MARK the areas on the Diagram with the following letters to describe your symptoms:

R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling



NAME: _____

History of Complaint – Section 3

Have you suffered with your current condition or a similar problem in the past? ☐ No ☐ Yes

If yes, how many times? _____ When was the last episode? _____

How did the injury happen? _____

Other forms of treatment tried: ☐ No ☐ Yes

If yes, please state what type of treatment: _____

Previous Chiropractic Care? ☐ Yes ☐ No Date of last Chiropractic visit: _____

Name of previous Chiropractor: _____ ☐ N/A

How long were you under care? _____

What were the results. ☐ Favorable ☐ Unfavorable

Please explain: _____

_____

NAME: _____

Activities of Daily Life

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Carry Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

NAME: _____

QUADRUPLE VISUAL ANALOG SCALE

Please read carefully.

Instructions: Please write your condition and circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example: **Headache** **Neck & Low Back**

(No pain) 0 ____1____(2)____3____4____(5)____6____7____8____9____10 (Worst possible pain)

1. **What is your pain RIGHT NOW?**

(No pain) 0 ____1____2____3____4____5____6____7____8____9____10 (Worst possible pain)

2. **What is your TYPICAL or AVERAGE pain?**

(No pain) 0 ____1____2____3____4____5____6____7____8____9____10 (Worst possible pain)

3. **What is your pain level AT ITS BEST** (How close to "0" does your pain get at its best)**?**

(No pain) 0 ____1____2____3____4____5____6____7____8____9____10 (Worst possible pain)

4. **What is your pain level AT ITS WORST** (How close to "10" does your pain get at its worst)**?**

(No pain) 0 ____1____2____3____4____5____6____7____8____9____10 (Worst possible pain)

OTHER COMMENTS:

_____

_____

_____