

NEW PATIENT INFORMATION

Understanding the health concerns brought you to our office, and their causes, is an important part of providing you effective analysis and proper care. Please take as much time as necessary to answer each of the following questions.

Please be as thorough and complete as possible.

Name: _____ Spouse: _____
 Address: _____ City: _____ State: _____ Zip: _____
 E-mail Address: _____ SS #: _____
 Hm Phone: _____ Date of Birth: _____ M S W D # of Children: _____
 Employer: _____ Wk Phone: _____
 What type of work (activities) do you do? _____
 Who should we thank for telling you about our office? _____

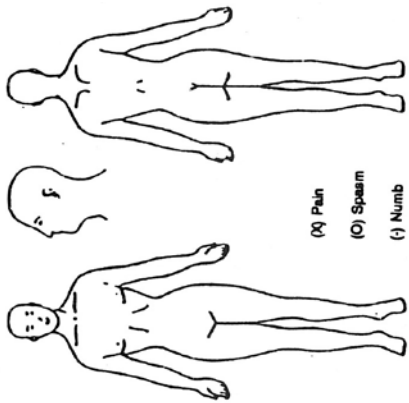
Please describe in detail the reason(s) for today's visit:

Concern #1: _____
 Approx Date of Onset: _____
 Degree: Mild Moderate Severe

Concern #2: _____
 Approx Date of Onset: _____
 Degree: Mild Moderate Severe

Concern #3: _____
 Approx Date of Onset: _____
 Degree: Mild Moderate Severe

Please mark **areas** and **quality** of any pain or symptoms that you want the doctor to be aware of:



Quality

- Ache
- Sharp
- Pound
- Burn
- Numb
- Tingle
- Radiating
- Swollen
- Spasm
- Stiff
- Weak
- Other

How often are you aware of your symptoms? _____

What position or activity that makes you feel worse? _____

What position or activity provides relief or makes you feel better? _____

Since your complaints began are they trending: Better Worse About the Same

How long have you had these complaints? _____ Days Weeks Months Years

What do you believe has caused your complaints? Work Injury Lifestyle Other: _____

Do these complaints interfere with: Work Sleep Sitting Walking Other: _____

Have you ever experienced this problem before? Yes No Many years ago

Have you consulted other doctors for these concerns? Yes No Who: _____

Have taken any medications for this complaint? Yes No What: _____

In general, how would you rate your overall health & vitality?
 (Challenged) ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (Excellent)

How concerned are you about protecting your future health & wellbeing?
 (Not) ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (Very)

PLEASE COMPLETE OTHER SIDE

YOUR HEALTH HISTORY

Many spinal/health challenges have their origins in the early and the development years of childhood. Please answer the following questions about your health history to the best of your ability. This will give the doctor very important information that will help in the clinical decision making process.

Please check (✓) any health issues that you now or have ever had:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Eyes / Vision | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Middle Back Pain | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Ears / Hearing | <input type="checkbox"/> Lungs/Breathing |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Throat / Voice | <input type="checkbox"/> Sinus Pain / Drainage | <input type="checkbox"/> Dental / TMJ |
| <input type="checkbox"/> Hip / Leg Pain | <input type="checkbox"/> Numbness | <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Cold Hands / Feet | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Shoulder /Arm Pain | <input type="checkbox"/> Seizures | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Shaking/Tremors | | |
| <input type="checkbox"/> Sleep Disorders | <input type="checkbox"/> Coughing or Wheezing | | |
| <input type="checkbox"/> Weak Muscles | <input type="checkbox"/> Excessive Thirst | | |
| <input type="checkbox"/> Urinary Problems | <input type="checkbox"/> Genital Pain | | |
| <input type="checkbox"/> Weight Loss / Gain | <input type="checkbox"/> Heartburn | | |

Female Only

- | | |
|--|--|
| <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Breast Lumps |
| <input type="checkbox"/> Back Pain w/ Period | <input type="checkbox"/> Breast Implants |
| <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> Breast Pain |

CHILDHOOD

- | | Yes | No | Unsure |
|---|--------------------------|--------------------------|--------------------------|
| Did you have a normal birth? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| As a child did you have any serious health issues? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| As a child did you have any serious injuries or broken bones? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| As a child did you play youth sports? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| As a child did you routinely take/use medications? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| As a child did you have any major surgeries? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| As a child did you ever fall or jump from a height over three feet? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| As a child were you involved in any automobile accidents? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| As a child were you under regular chiropractic care? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments: _____

ADULTHOOD

- | | Yes | No |
|--|--------------------------|--------------------------|
| Do you exercise 3 or more times per week? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any serious or injuries or broken bones? | <input type="checkbox"/> | <input type="checkbox"/> |
| have you been involved in any automobile accidents? | <input type="checkbox"/> | <input type="checkbox"/> |
| As an adult, have you had any major surgeries? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you seem to catch colds or the flu easily? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you regularly use medications for pain? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you missed work in the past year due to illness? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have any of your co-workers expressed similar health concerns? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have <input type="checkbox"/> physical or <input type="checkbox"/> mental stress at <u>work</u> ? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have <input type="checkbox"/> physical or <input type="checkbox"/> mental stress at <u>home</u> ? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | | | |
|-----------------------------------|------------------------------------|-------------------------------|------------------------------|---------------------------------|
| How well do you sleep? | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Bad | <input type="checkbox"/> Unsure |
| How well do you deal with stress? | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Bad | <input type="checkbox"/> Unsure |
| How is your diet? | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Bad | <input type="checkbox"/> Unsure |
| How are your energy levels? | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Bad | <input type="checkbox"/> Unsure |
| How do you think your posture is? | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Bad | <input type="checkbox"/> Unsure |

I understand that my care in this office involves the making of judgements that are based upon the facts known by the doctor. Therefore, the above information is true and complete to the best of my knowledge.

X: _____
Patient's Signature

_____/_____/_____
Date