

NEW PATIENT FORM ADULT



PATIENT INFORMATION

Name _____ Today's Date _____ Referred by _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Birthday _____ Age _____ Gender M F Are you pregnant? No Yes

Significant Other's Name _____ Kid's Names and Ages _____

Your Employer _____ Occupation _____

e-Mail Address _____ Have you been to a chiropractor before?
 No Yes

Emergency Contact _____ Relation _____ Phone _____

Name of Medical Doctor _____ Phone _____

INFORMED CONSENT

REASON FOR SEEKING CARE

What is the purpose of your visit? Preventative Wellness Complaint Auto Accident Injury Work Injury

Main Complaint _____

Additional Health Concerns _____

When did this begin? _____

Describe: Dull Sharp Ache Numb/Tingly

Explain _____

Pain radiates to _____

Constant Frequent Occasional

Rate pain from 0 to 10 (0 = no pain, 10 = disabling)

Is the pain: Staying the same Getting worse Getting better

Worse in the morning Worse in the evening

What makes it worse? _____

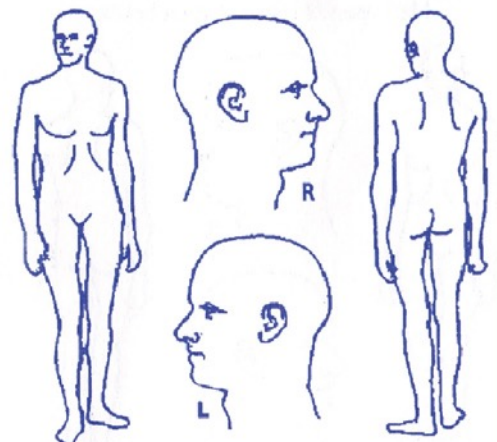
What makes it better? _____

Does your condition affect: Sleeping Working Walking

Sitting Driving Standing Your Daily Routine

What Doctor(s) have you seen for this?

Please mark all areas of concern



HEALTH HISTORY

Patient Name _____
you.

Please mark the conditions that apply to you.

GENERAL

Past Current

- Chronic Fatigue
 Tobacco Use
 Alcohol Use
 Cancer
 Dizziness

RESPIRATORY

Past Current

- Shortness of breath
 Asthma
 Pneumonia
 Emphysema

EYES, EARS, NOSE, THROAT

Past Current

- Allergies
 Throat Problems
 Ear Problems
 Nose Problems
 Eye Problems

NEUROLOGICAL

Past Current

- Ringing in the ears
 Headaches
 Migraines
 Arthritis
 Leg/Foot Numbness
 Seizures

GASTRO-INTESTINAL

Past Current

- Diarrhea
 Chron's Disease
 Digestive Problems
 Acid Reflux
 Constipation
 Gallbladder Problems
 Liver Problems

GENITO-URINARY

Past Current

- Urinary Problems
 Kidney Problems
 Kidney Stones
 Bed Wetting
 Prostate Problems

MUSCULOSKELETAL

Past Current

- Muscle Aches
 Trouble Walking
 Joint Stiffness
 Muscle Weakness
 Osteoporosis
 Joint Replacement

ENDOCRINE

Past Present

- Hot Flashes
 Hair Loss
 Type I Diabetes
 Type II Diabetes
 Menstrual Problems
 Hypothyroidism
 Hyperthyroidism

CARDIOVASCULAR

Past Current

- Easy Bruising
 Poor Circulation
 High Blood Pressure
 Low Blood Pressure
 Heart Disease
 Heart Attack
 High Cholesterol
 Stroke
 Pacemaker

MENTAL HEALTH

Past Present

- Anxiety
 Depression

Other: _____

PAST HISTORY

List any past auto accidents: _____

Was any care received?

List any past work injuries: _____

Was any care received?

List any past sport, recreational or home injuries:

FAMILY HEALTH HISTORY

Father's side: Heart Disease Cancer Diabetes Heavy Medication use Arthritis

Other _____

Mother's side: Heart Disease Cancer Diabetes Heavy Medication use Arthritis

Other _____