NEW PATIENT FORM
ADULT

Olive Me CHIROPRACTIC

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 _____

When did this begin? _____

Describe: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb/Tingly

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?

_____

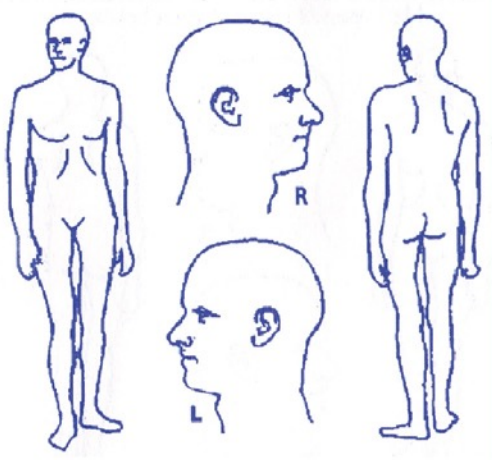
Additional Health Concerns _____

_____

Explain _____

_____

Please mark all areas of concern



HEALTH HISTORY

Patient Name _____ *Please mark the conditions that apply to you.*

GENERAL

Past	Current	
☐	☐	Chronic Fatigue
☐	☐	Tobacco Use
☐	☐	Alcohol Use
☐	☐	Cancer
☐	☐	Dizziness

NEUROLOGICAL

Past	Current	
☐	☐	Ringing in the ears
☐	☐	Headaches
☐	☐	Migraines
☐	☐	Arthritis
☐	☐	Leg/Foot Numbness
☐	☐	Seizures

MUSCULOSKELETAL

Past	Current	
☐	☐	Muscle Aches
☐	☐	Trouble Walking
☐	☐	Joint Stiffness
☐	☐	Muscle Weakness
☐	☐	Osteoporosis
☐	☐	Joint Replacement

MENTAL HEALTH

Past	Present	
☐	☐	Anxiety
☐	☐	Depression

RESPIRATORY

Past	Current	
☐	☐	Shortness of breath
☐	☐	Asthma
☐	☐	Pneumonia
☐	☐	Emphysema

GASTRO-INTESTINAL

Past	Current	
☐	☐	Diarrhea
☐	☐	Chron's Disease
☐	☐	Digestive Problems
☐	☐	Acid Reflux
☐	☐	Constipation
☐	☐	Gallbladder Problems
	☐	☐ Liver Problems

ENDOCRINE

Past	Present	
☐	☐	Hot Flashes
☐	☐	Hair Loss
☐	☐	Type I Diabetes
	☐	☐ Type II Diabetes
☐	☐	Menstrual Problems
☐	☐	Hypothyroidism
☐	☐	Hyperthyroidism

EYES, EARS, NOSE, THROAT

Past	Current	
☐	☐	Allergies
☐	☐	Throat Problems
☐	☐	Ear Problems
☐	☐	Nose Problems
☐	☐	Eye Problems

GENITO-URINARY

Past	Current	
☐	☐	Urinary Problems
☐	☐	Kidney Problems
☐	☐	Kidney Stones
☐	☐	Bed Wetting
☐	☐	Prostate Problems

CARDIOVASCULAR

Past	Current	
☐	☐	Easy Bruising
☐	☐	Poor Circulation
	☐	☐ High Blood Pressure
☐	☐	Low Blood Pressure
	☐	☐ Heart Disease
☐	☐	Heart Attack
☐	☐	High Cholesterol
☐	☐	Stroke
	☐	☐ Pacemaker

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_____