



NEW PATIENT INFORMATION

Name:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Today's Date:
Address:	City/State/Zip:	
Home Phone: ()	Work Phone: ()	Date of Birth:
Age:	Social Security#:	Marital Status: <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> S
Occupation:	Employer:	Name of Spouse:
Number of Children:	Ages of Children:	
Insurance type:	<input type="checkbox"/> Health <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Car accident <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> Other	
Who may we thank for referring you to our office?		

Welcome to our office! Please complete all questions.

ARE YOU HERE FOR WELLNESS CARE OR FOR A SYMPTOM? Wellness Symptom

If you have a specific symptom(s), fill out this box and briefly describe each one in order of severity:

1. (Main complaint) _____
2. _____
3. _____
4. _____
5. _____

How long have you had your main complaint? _____

Have you ever had this before? Yes No When? _____

Was this related to: Auto Accident Work Accident

Have you lost work days? Yes No If so, how many? _____

HOW DO YOU WANT TO HANDLE THIS PROBLEM?

Temporary relief (Help the symptom but don't fix the cause of the problem)

Maximum correction (Correct the cause of the problem for maximum stability in the future)

(please turn over)

List drugs you are currently taking(prescription and non-prescription)_____

What surgeries have you had?_____

Is there any chance you are pregnant? Yes No

Have you ever been diagnosed with cancer? Yes No If so, what kind?_____

When did you last see a chiropractor?_____ Dr._____

What spinal maintenance programs were you given to maximize the future stability of your spine?_____

Did you follow them? Yes No If not, was there a reason you didn't?_____

Why are you changing chiropractors?_____

1. What are your favorite hobbies or activities?_____

2. Are your current problems affecting these activities or hobbies?_____

3. What activities do you look forward to doing in retirement?_____

On a scale of 1-10 (10 being most, and 1 being least),

_____ How committed are you to being at your maximum health potential?

_____ How important is it for your family to be at their optimum health potential?

_____ How committed are you to preventing arthritis and maximizing your spinal stability?

PLEASE CHECK ANY OF THE FOLLOWING THAT GIVE YOU DIFFICULTY:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Depression | <input type="checkbox"/> Mid-back pain | <input type="checkbox"/> Kidney trouble |
| <input type="checkbox"/> Shooting head pains | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart attacks | <input type="checkbox"/> Menstrual cramps and pain |
| <input type="checkbox"/> Sinus Troubles | <input type="checkbox"/> Fainting | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Menstrual irregularity |
| <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Stomach trouble | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Light bothers eyes | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Painful joints |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Inner tension | <input type="checkbox"/> Swollen joints |
| <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Muscle spasms in neck | <input type="checkbox"/> Irritability | <input type="checkbox"/> Pinched nerves in back |
| <input type="checkbox"/> Tightness of throat | <input type="checkbox"/> Tightness of shoulder muscles | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Pins and needles in legs |
| <input type="checkbox"/> Inflammation of throat | <input type="checkbox"/> Pain in shoulders and arms | <input type="checkbox"/> Gall bladder trouble | <input type="checkbox"/> Swollen ankles |
| <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> Pins and needles arms/hands | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Twitching of face | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Intestinal gas | <input type="checkbox"/> Pains in legs and feet |
| <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Chest pains | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Pain when coughing | <input type="checkbox"/> Numbness in the low back | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Lung problems | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Excess sweating |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Dyslexia | <input type="checkbox"/> Liver problems |

Signature: _____

Date: _____