



**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: \_\_\_\_\_



8. Do you have any bruises?  Yes  No  
If yes, on what part(s) of the body? \_\_\_\_\_
9. Did you feel immediate pain?  Yes  No  
If yes, where did you feel the pain?  
 Head  Mid Back  Extremity \_\_\_\_\_  
 Neck  Low Back  Other \_\_\_\_\_
- If not, when did your pain start? \_\_\_\_\_
10. Did you or do you feel:  Dizzy  Blurry Vision  Loss of Memory  
 Ringing in the Ears  Head Feels Heavy  Loss of Sleep
11. Were you wearing your seat belt?  Yes  No
12. After the accident, did you:  
 Go Home  Go About Your Business  Go to Hospital

### HOSPITAL

13. If taken to the hospital, how?  
 By Ambulance  Drove by Yourself  Driven by Friend

Name of Hospital \_\_\_\_\_

Were you seen in the Emergency Room?  Yes  No

Were you admitted to the hospital?  Yes  No

If admitted, how long did you stay? \_\_\_\_\_

Name of admitting or hospital physician \_\_\_\_\_

In Emergency Room or Hospital – What was done?

- Examination  Cervical collar  Complete bed rest  
 X-Rays  Stitches  Physiotherapy  
 Prescription  Other \_\_\_\_\_

14. After your release – What did you do?  
 Return to Work  Return Home To Bed  Other \_\_\_\_\_

15. Did you consult another physician?  Yes  No  
 Name of DR. \_\_\_\_\_  
 Date of Visit \_\_\_\_\_  
 What did he do for you? \_\_\_\_\_  
 Are you still seeing him?  Yes  No

### PAST HISTORY

16. Have you been in any previous accidents? \_\_\_\_\_
17. Have you ever been treated for neck or back problems before? \_\_\_\_\_

18. Have you enjoyed good health prior to the accident? \_\_\_\_\_

19. Have you had previous surgery or conditions that I should know about? \_\_\_\_\_  
\_\_\_\_\_

20. What are your present complaints? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

21. Did you miss work as a result of the accident?     Yes     No  
If yes, what dates? \_\_\_\_\_

22. Do you have an attorney representing you?     Yes     No  
If yes, please write your attorney's information below:  
Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Phone # \_\_\_\_\_

23. Since the accident, have you been Unable to:  
 Return to Work     Exercise     Resume daily activities  
 Drive     Sleep     Other \_\_\_\_\_

Since the accident are you:

- Bedridden
  - Walking with a limp
  - Having psychological side effects
  - Having anxiety while driving
  - In need of live-in help to care for yourself
  - In need of assistance of a walker, wheelchair, cane or crutches
  - Able to return to work
  - Able to return to work on light duty only
- Restrictions:     No Bending  
                           No Lifting  
                           No Twisting

24. Additional Comments \_\_\_\_\_