

NEW PATIENT INFORMATION

Welcome to our office! Please complete all questions.

Name:		Date:	
Address:		City/State/Zip:	
Home Phone:	Work Phone:	Cell:	
Email Address:			
Birth date:	Age:	Soc. Sec. #	
Marital Status:	M	W	D S
Your Employer:		Occupation:	
Spouse's Name		Spouse's Occupation:	
Children's Names and Ages:			
Favorite Hobbies or Interests:			
Method of Payment for First Visit:		Cash	Check Credit Card

Is today's visit for: wellness care specific problem

What health goals may we help you with? _____

Who may we thank for referring you? _____

Have you ever visited a chiropractor? _____ If yes who? _____

If this is for a specific problem, please list other doctors you've seen: _____

Do you smoke any tobacco products? _____ If yes, how often? _____

Surgeries you have had: _____

Medications that you currently take: _____

Is there any chance you are pregnant? _____

Have you ever been diagnosed with cancer? _____ If so, what kind? _____

Do you have health insurance? _____ Name of company: _____

Are you experiencing or have you experienced any of these symptoms in the past year?

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Pain between shoulders | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Arm/Leg Pain |
| <input type="checkbox"/> Joint Pain/Stiffness | <input type="checkbox"/> Clicking Jaw | <input type="checkbox"/> General Stiffness | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Depression/Confusion | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> in Arms/Legs | <input type="checkbox"/> Asthma | <input type="checkbox"/> Severe Emotional Trauma | |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Breast Pain/Lumps | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Sexual Dysfunction |

The following information is true and accurate to the best of my knowledge. X _____

Vertebral Subluxations frequently don't cause pain, but they may. If you came to our office for a specific condition please answer the following questions.

1. Which pain or condition you have checked is the worst? _____
2. How long has it bothered you? _____
3. Vertebral Subluxations can cause irritation to different fibers within nerves. Are your pains sharp or dull? _____
4. Subluxations can put pressure on the spinal cord that can be constant or occasional. Which do you feel? _____
5. Pressure on the spinal cord or nerves can be worse in the AM or PM Which one is harder for you? _____
6. Does this pain radiate into an arm or leg or stay in one area? _____
7. Is there anything else that you would like the doctor to know about your health that has not been covered?

Our patients have had literally dozens of impacts that could cause subluxations. I want to discover several of yours.

1. The birthing process can be very traumatic to a spine. Do you know any detail from your birth that may be important? (forceps, suction, C-section, drug induced, nerve blocks)

2. Many of our patients have had slips or falls as a child. What stick out in your mind from your childhood?

3. The average person has a car accident every ten years. When was your most recent auto accident? _____
 - a. Speed: _____
 - b. Front or side collision/ or rear end? _____
 - c. Was treatment received? YES NO If yes, what,? _____
 - d. Please describe any others that you may have had

4. Most people do work that is either repetitive or physically taxing.
 - a. What could be contributing to subluxation in your line of work?

 - b. Please describe any stresses or strains at work not covered above

 - c. What types of jobs have you done?

5. Please describe any stresses or strains you have had while participating in recreational activities or sports.

6. Is there any other injury to your spine, minor or major that the doctor should know about?