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New Patient Form

Patient Information

Date _____

Patient _____

Address _____

_____
City State Zip

Sex: ☐ M ☐ F Age _____ Birthdate _____

Height _____ Weight _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Referral from: ☐ Phone Book ☐ Other _____

Individual (name please) _____

Phone Numbers

Home _____ Work _____ Ext _____

Best time and place to reach you _____

IN CASE OF EMERGENCY CONTACT:

Name _____ Relationship _____

Home Phone _____

Work Phone _____ Ext _____

Accident Information

Is condition due to an accident? ☐ Yes ☐ No

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other

Injury Date _____ Time _____ Work Related? _____

X-rays taken since injury? ☐ Yes ☐ No

If so, when and where? _____

What aggravates your condition? _____

What helps relieve your discomfort? _____

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp ☐ Other

Attorney Name (if applicable) _____

Patient Condition

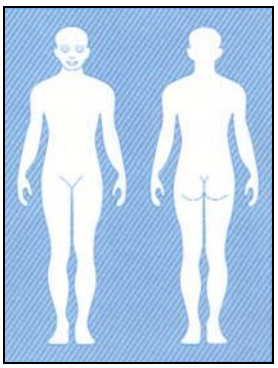
Reason for Visit _____

When did your symptoms appear? _____ Is this condition worsening? ☐ Yes ☐ No

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Areas of Complaint: (Mark Area of Pain with an X)

Headaches	_____	Hip	_____	Shoulder	_____
Neck Pain	_____	Knee	_____	Chest	_____
Midback	_____	Ankle	_____	Ribs	_____
Low Back	_____	Foot	_____	Elbow	_____
Sacroiliac	_____			Wrist	_____



Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform:
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

I Hereby Assign Payment directly to this office for professional services rendered and I shall be personally responsible for any unpaid balance to the doctor.

Insured Signature _____ Date: _____

Health History

Patient Name _____

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated your for your condition _____

_____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
Spinal Exam _____ Chest X-Ray _____ Urine Test _____
Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	Miscarriage ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Alcoholism ☐ Yes ☐ No	Epilepsy ☐ Yes ☐ No	Mononucleosis ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Allergy Shots ☐ Yes ☐ No	Fractures ☐ Yes ☐ No	Multiple Sclerosis ☐ Yes ☐ No	Suicide Attempt ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Mumps ☐ Yes ☐ No	Thyroid
Anorexia ☐ Yes ☐ No	Goiter ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Problems ☐ Yes ☐ No
Appendicitis ☐ Yes ☐ No	Gonorrhea ☐ Yes ☐ No	Pacemaker ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No	Gout ☐ Yes ☐ No	Parkinson's	Tuberculosis ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Heart Disease ☐ Yes ☐ No	Disease ☐ Yes ☐ No	Tumors,
Bleeding	Hepatitis ☐ Yes ☐ No	Pinched Nerve ☐ Yes ☐ No	Growths ☐ Yes ☐ No
Disorders ☐ Yes ☐ No	Hernia ☐ Yes ☐ No	Pneumonia ☐ Yes ☐ No	Typhoid Fever ☐ Yes ☐ No
Breast Lump ☐ Yes ☐ No	Herniated Disk ☐ Yes ☐ No	Polio ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Bronchitis ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Prostate	Vaginal
Bulimia ☐ Yes ☐ No	High	Problem ☐ Yes ☐ No	Infections ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Cholesterol ☐ Yes ☐ No	Prosthesis ☐ Yes ☐ No	Venereal
Cataracts ☐ Yes ☐ No	Kidney Disease ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Disease ☐ Yes ☐ No
Chemical	Liver Disease ☐ Yes ☐ No	Rheumatoid	Whooping Cough ☐ Yes ☐ No
Dependency ☐ Yes ☐ No	Measles ☐ Yes ☐ No	Arthritis ☐ Yes ☐ No	Other _____
Chicken Pox ☐ Yes ☐ No	Migraine	Rheumatic	_____
Diabetes ☐ Yes ☐ No	Headaches ☐ Yes ☐ No	Fever ☐ Yes ☐ No	_____

EXERCISE
☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS
☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications **Allergies** **Vitamins/Herbs/Minerals**

_____

_____

_____