New Patient Form

Date: _______________

Patient name: ______________________________ M F Date of Birth: _____/_____/_____

SS# ___________________________

Address: ________________________________ City: ___________ State: ____ Zip Code: ______

Home Phone #: ________________ Cell #: ___________________ Work #: ________________

Email: ____

Emergency Contact: ______________________ Emergency Phone #: _______________________

Referred by: ____

Primary Care Physician____

Primary Care Physician Phone # ____

Address____

Employer ___________________________________ Job Title ________________________

Hobbies/Sports ____

Are you: ☐ Right-handed ☐ Left-handed

In the last 2 years have you been involved in a Work Injury, Personal Injury, or Motor Vehicle Accident injury? ☐ YES ☐ NO

Date _________________Type of accident ___________________________________

Chief Complaints/Injuries: ____

____

____

Have you ever seen a chiropractor? ☐ Yes ☐ No How long ago? ____________________

Where?___________________ For what condition? ______________________

Results: ☐ no change ☐ minimal improvement ☐ great improvement ☐ complete relief

Are you treating with any other doctors for this condition? ☐ Yes ☐ No

Who? ____

Have you had any Diagnostic tests done recently? ☐ MRI ☐ CAT ☐ X-Ray ☐ EMG

If yes, where & when? ____

Health Insurance Information

Insurance Carrier____________________________ Plan Type_____________

Ref required? Y or N

ID #_____________________________Group #_______________________

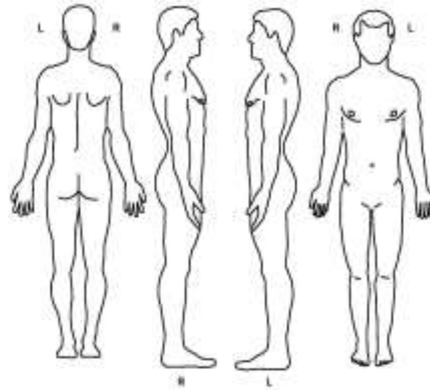
Phone #____

Employer insurance is through? _____________________________________

Who is the Policy Holder? ____

Secondary Insurance? ____

Please indicate on the drawings below where you have any pain symptoms in order of severity of pain:



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COMPLAINTS: (List ONE region at a time. For extra areas please see Secondary & Tertiary Complaints.)
Primary Complaint: (Your main symptom)

☐ Neck ☐R ☐L | ☐ Lower Back ☐R ☐L | ☐ Upper Back ☐R ☐L | ☐ Mid Back ☐R ☐L
☐ Headaches ☐R ☐L | ☐ Leg ☐R ☐L | ☐ Jaw ☐R ☐L | ☐ Hip ☐R ☐L
☐ Shoulder ☐R ☐L | ☐ Knee ☐R ☐L | ☐ Elbow/Wrist ☐R ☐L | ☐ Foot/Ankle ☐R ☐L
☐ Arm/Hand ☐R ☐L | ☐ No Pain | ☐ Other ____________

1. How would you describe the type of pain?
☐ Achy ☐Burning ☐ Dull ☐Generally achy, but occasionally sharp
☐Numb ☐Sharp ☐Shooting ☐Sore
☐Stiff ☐Stiff & Sore ☐Tingling ☐Other ________________________________

2. How would you rank the severity of your pain?
☐Minimal ☐Mild ☐Mild toMod. ☐Moderate
☐Moderate to severe ☐Severe ☐Debilitating

3. When did your problem(s) begin? ☐ the day of the accident ☐gradually ☐unknown ☐ date: ___________
☐______ days ago ☐______ weeks ago ☐ ______ months ago ☐______ years ago

4. How often do you have pain? ☐constant ☐frequent ☐occasional ☐off and on

5. How do you think it began? ☐auto accident ☐work injury ☐lifting injury ☐unknown
☐repetitive use injury ☐sports injury ☐ other _______________________________________

6. Does your pain radiate anywhere? ☐ Yes ☐ No Where? ____

7. Using a scale from 0-10 (10 being the worst), how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

8. What aggravates your problem?
☐ sitting ☐ standing ☐ lying down ☐ with movement ☐ with use
☐ walking ☐ running ☐ working ☐ golfing ☐ bending
☐ computer work ☐ exercise ☐ driving ☐ weather changes ☐ standing up
☐ looking down ☐ looking up ☐ reading ☐ ______________ ☐ _____________

9.What alleviates your problem?
☐ sitting ☐ standing ☐ lying down ☐ movement
☐ walking ☐ running ☐ working ☐ with use
☐ warm baths ☐ exercising ☐ massage ☐ pain relievers
☐ heat ☐ice ☐___________________ ☐ ___________________

Is there a time of day when your pain is at its worst? ☐morning ☐afternoon ☐evening ☐bedtime
Is there a time of day when you have noticeably less pain? ☐morning ☐afternoon ☐evening ☐bedtime

Have you ever experienced these exact or similar symptoms before? If so, when?
☐No ☐Similar (explain) _________________________ ☐Same When? ______________________________

Secondary Complaint (2nd symptom – if necessary)

☐ Neck ☐R ☐L ☐ Lower Back ☐R ☐L ☐ Upper Back ☐R ☐L ☐ Mid Back ☐R ☐L
☐ Headaches ☐R ☐L ☐ Leg ☐R ☐L ☐ Jaw ☐R ☐L ☐ Hip ☐R ☐L
☐ Shoulder ☐R ☐L ☐ Knee ☐R ☐L ☐ Elbow/Wrist ☐R ☐L ☐ Foot/Ankle ☐R ☐L
☐ Arm/Hand ☐R ☐L ☐ No Pain ☐ Other ____________

1. How would you describe the type of pain?
☐ Achy ☐ Burning ☐ Dull ☐ Generally achy, but occasionally sharp
☐ Numb ☐ Sharp ☐ Shooting ☐ Sore
☐ Stiff ☐ Stiff & Sore ☐ Tingling ☐ Other ________________________________

2. How would you rank the severity of your pain?
☐ Minimal ☐ Mild ☐ Mild to Mod. ☐ Moderate
☐ Moderate to severe ☐ Severe ☐ Debilitating

3. When did your problem(s) begin? ☐ the day of the accident ☐gradually ☐ unknown ☐ date: ___________
☐______ days ago ☐______ weeks ago ☐ ______ months ago ☐______ years ago

4. How often do you have pain? ☐ constant ☐ frequent ☐ occasional ☐ off and on

5. How do you think it began? ☐ auto accident ☐ work injury ☐ lifting injury ☐ unknown
☐ repetitive use injury ☐ sports injury ☐ other ______________________________________

6. Does your pain radiate anywhere? ☐ Yes ☐ No Where? ____

7. Using a scale from 0-10 (10 being the worst), how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

8. What aggravates your problem?
☐ sitting ☐ standing ☐ lying down ☐ with movement ☐ with use
☐ walking ☐ running ☐ working ☐ golfing ☐ bending
☐ computer work ☐ exercise ☐ driving ☐ weather changes ☐ standing up
☐ looking down ☐ looking up ☐ reading ☐ ______________ ☐ _____________

9.What alleviates your problem?
☐ sitting ☐ standing ☐ lying down ☐ movement
☐ walking ☐ running ☐ working ☐ with use
☐ warm baths ☐ exercising ☐ massage ☐ pain relievers
☐ heat ☐ice ☐__________________ ☐ __________________

Is there a time of day when your pain is at its worst? ☐morning ☐afternoon ☐evening ☐bedtime
Is there a time of day when you have noticeably less pain? ☐morning ☐afternoon ☐evening ☐bedtime

Have you ever experienced these exact or similar symptoms before? If so, when?
☐No ☐Similar (explain) _________________________ ☐Same When? ______________________________

Tertiary Complaint (3rd Symptom – if necessary)

☐ Neck ☐R ☐L ☐ Lower Back ☐R ☐L ☐ Upper Back ☐R ☐L ☐ Mid Back ☐R ☐ L
☐ Headaches ☐R ☐L ☐ Leg ☐R ☐L ☐ Jaw ☐R ☐L ☐ Hip ☐ R ☐ L
☐ Shoulder ☐R ☐L ☐ Knee ☐R ☐L ☐ Elbow/Wrist ☐R ☐L ☐ Foot/Ankle ☐R ☐ L
☐ Arm/Hand ☐R ☐L ☐ No Pain ☐ Other ____________

1. How would you describe the type of pain?
☐ Achy ☐ Burning ☐ Dull ☐ Generally achy, but occasionally sharp
☐ Numb ☐ Sharp ☐ Shooting ☐ Sore
☐ Stiff ☐ Stiff & Sore ☐Tingling ☐ Other ________________________________

2. How would you rank the severity of your pain?
☐ Minimal ☐ Mild ☐ Mild to Mod. ☐ Moderate
☐ Moderate to severe ☐ Severe ☐ Debilitating

3. When did your problem(s) begin? ☐ the day of the accident ☐gradually ☐unknown ☐ date: ___________
☐______ days ago ☐______ weeks ago ☐ ______ months ago ☐______ years ago

4. How often do you have pain? ☐ constant ☐ frequent ☐ occasional ☐ off and on

5. How do you think it began? ☐ auto accident ☐ work injury ☐ lifting injury ☐ unknown
☐ repetitive use injury ☐ sports injury ☐ other ______________________________________

6. Does your pain radiate anywhere? ☐ Yes ☐ No Where? ____

7. Using a scale from 0-10 (10 being the worst), how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

8. What aggravates your problem?

☐ sitting ☐ standing ☐ lying down ☐ with movement ☐ with use
☐ walking ☐ running ☐ working ☐ golfing ☐ bending
☐ computer work ☐ exercise ☐ driving ☐ weather changes ☐ standing up
☐ looking down ☐ looking up ☐ reading ☐ ______________ ☐ _____________

9.What alleviates your problem?

☐ sitting ☐ standing ☐ lying down ☐ movement
☐ walking ☐ running ☐ working ☐ with use
☐ warm baths ☐ exercising ☐ massage ☐ pain relievers
☐ heat ☐ice ☐__________________ ☐ ___________________

Is there a time of day when your pain is at its worst? ☐morning ☐afternoon ☐evening ☐bedtime
Is there a time of day when you have noticeably less pain? ☐morning ☐afternoon ☐evening ☐bedtime

Have you ever experienced these exact or similar symptoms before? If so, when?
☐No ☐ Similar (explain) _________________________ ☐ Same When? _______________________________

Background Information

Age ______ Race: ☐African Amer. ☐Amer. Indian ☐Asian ☐Caucasian ☐Hispanic ☐Mid. Eastern ☐ Other____

Height _____ft._____in. Weight ________lbs. Occupation __________________________________

Exercise: ☐ Never ☐ Occasionally ☐ Frequently ☐ Daily Do you smoke?: ☐ Yes ☐ No _____ packs/day

Do you consume alcohol? ☐ Yes ☐ No ☐ socially ☐ occasionally ☐ frequently ☐ daily

Have you had any of the following treatments in the past? What was done, when and how effective?

1.Anti-inflammatories: Type _________________ ☐comp. relief ☐great imp. ☐min. imp. ☐no imp. When?________
2.Muscle relaxors: Type _________________ ☐comp. relief ☐great imp. ☐min. imp. ☐no imp. When?________
3.Pain medications: Type _________________ ☐comp. relief ☐great imp. ☐min. imp. ☐no imp. When?________
4.Physical Therapy: Where _________________ ☐comp. relief ☐great imp. ☐min. imp. ☐no imp. When?________
5.Surgeries: ____________________________ ☐comp. relief ☐great imp. ☐min. imp. ☐no imp. When?________
6.Chiropractic care: Where _________________ ☐comp. relief ☐great imp. ☐min. imp. ☐no imp. When?________

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	
☐	☐	Headaches
☐	☐	Neck Pain
☐	☐	Upper Back Pain
☐	☐	Mid Back Pain
☐	☐	Low Back Pain
☐	☐	Shoulder Pain
☐	☐	Elbow/Upper Arm Pain
☐	☐	Wrist Pain
☐	☐	Hand Pain
☐	☐	Hip Pain
☐	☐	Upper Leg Pain
☐	☐	Knee Pain
☐	☐	Chronic Sinusitis
☐	☐	Ankle/Foot Pain
☐	☐	Jaw Pain
☐	☐	Joint Pain/Stiffness
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	General Fatigue
☐	☐	Muscular Incoordination
☐	☐	Visual Disturbances
☐	☐	Other: ______________________________

Past	Present	
☐	☐	Dizzines
☐	☐	High Blood Pressure
☐	☐	Heart Attack
☐	☐	Chest Pains
☐	☐	Stroke
☐	☐	Angina
☐	☐	Kidney Stones
☐	☐	Kidney Disorders
☐	☐	Bladder Infection
☐	☐	Painful Urination
☐	☐	Loss of Bladder Control
☐	☐	Prostate Problems
☐	☐	Abnormal Wt. Gain/Loss
☐	☐	Loss of Appetite
☐	☐	Abdominal Pain
☐	☐	Ulcer
☐	☐	Hepatitis
☐	☐	Liver/GallBladder Disorder
☐	☐	Cancer
☐	☐	Tumor

Past	Present	
☐	☐	Diabetes
☐	☐	Excessive Thirst
☐	☐	Frequent Urination
☐	☐	Smoking/Tobacco Use
☐	☐	Drug/Alcohol Dependence
☐	☐	Allergies
☐	☐	Depression
☐	☐	Systemic Lupus
☐	☐	Epilepsy
☐	☐	Dermatitis/Eczema/Rash
☐	☐	HIV/AIDS
☐	☐	Asthma

FOR FEMALES ONLY

Past	Present	
☐	☐	Birth Control Pills
☐	☐	Hormonal Replacement
☐	☐	Pregnancy
☐	☐	Dysmenorrhea (cramps)
☐	☐	Endometriosis
☐	☐	Menopause Symptoms

List all prescription or over-the-counter medications you are currently taking:

____

List all the supplements you are currently taking:

____

List all surgical procedures you have had:

____

Do you have any history of the following health problems in your family?

Respiratory disease	☐ Mother	☐ Father	☐ Grandmother	☐ Grandfather
Hypertension (high blood pressure)	☐ Mother	☐ Father	☐ Grandmother	☐ Grandfather
Gastro-Intestinal disease	☐ Mother	☐ Father	☐ Grandmother	☐ Grandfather
Diabetes	☐ Mother	☐ Father	☐ Grandmother	☐ Grandfather
Skin Disease	☐ Mother	☐ Father	☐ Grandmother	☐ Grandfather
Neurological disease	☐ Mother	☐ Father	☐ Grandmother	☐ Grandfather
Arthritis	☐ Mother	☐ Father	☐ Grandmother	☐ Grandfather
Stroke	☐ Mother	☐ Father	☐ Grandmother	☐ Grandfather
Cancer (type)	☐ Mother	☐ Father	☐ Grandmother	☐ Grandfather
Heart disease	☐ Mother	☐ Father	☐ Grandmother	☐ Grandfather

Have you ever been hospitalized? ☐ Yes ☐ No When? ____
For what? ____

Have you had any significant past trauma? ☐ Yes ☐ No When? ____________________________________
Explain. ____
____

Any other pertinent information you need to share with us? ____
____
____
____