CHIROPRACTIC ENTRANCE AND HISTORY

1. NEW PATIENT INFORMATION

DATE ___/___/_____

NAME _____

ADDRESS _____

_____

DATE OF BIRTH ____/____/_____ AGE ____ SEX M/F

PHONE (_____) _____ CELL (_____) _____

*E-MAIL _____

Whom may we thank for referring you? _____

___MARRIED ___SINGLE ___PARTNERED

OCCUPATION _____

_____

FAMILY INFORMATION - OTHERS IN HOUSEHOLD

SPOUSE/PARTNER _____

CHILDREN'S NAME(S) _____

(OR OTHERS) _____

_____

_____

3. RELATED INFORMATION

IS THE PROBLEM (S) IN BOX 2 RELATED DIRECTLY TO A MOTOR VEHICLE-RELATED OR WORK-RELATED INJURY? Y/N

PLEASE DESCRIBE _____

_____

_____

PLEASE LIST ANY ILLNESSES OR OTHER PROBLEMS THAT YOU WOULD BE EXCITED TO CORRECT _____

_____

_____

IS THERE AN INSURANCE PLAN YOU WOULD LIKE TO USE IF POSSIBLE? Y/N

INSURANCE COMPANY _____

PROVIDER SERVICES OR CUSTOMER SERVICE PHONE NUMBER ON CARD (_____) _____

ID# _____

SUBSCRIBER'S NAME _____

SUBSCRIBER'S DATE OF BIRTH ____/____/_____

RELATION TO PATIENT _____

IS THERE ANOTHER INSURANCE PLAN Y/N

HOW DID YOU HEAR ABOUT US? _____

PLEASE LIST THE NAME/TOWN OF YOUR LAST CHIROPRACTOR

_____

2. WHAT HEALTH PROBLEMS WOULD YOU LIKE TO CORRECT?

MAIN REASON FOR VISIT _____

_____

WHEN AND HOW DID THIS PROBLEM FIRST OCCUR?

_____

_____

_____

IS THIS GETTING PROGRESSIVELY WORSE? Y/N

WHAT MAKES THIS PROBLEM BETTER? _____

_____

WHAT MAKES THIS PROBLEM WORSE? _____

_____

PLEASE DESCRIBE HOW THIS PROBLEM FEELS

☐SHARP ☐DULL ☐ACHY ☐THROBBING ☐STIFF
☐BURNING ☐TINGLING ☐NUMB ☐SHOOTING
☐CRAMPING ☐OTHER _____

PLEASE RATE THE SEVERITY ON A 1-10 SCALE ____

1=MINIMAL 10=SEVERE

HOW OFTEN DOES THIS OCCUR? _____

☐COMES AND GOES ☐CONSTANT

WHAT TYPE OF ACTIVITIES DOES THIS INTERFERE WITH? ☐WORK ☐SLEEP ☐SITTING ☐STANDING
☐WALKING ☐MOVEMENT ☐EXERCISE

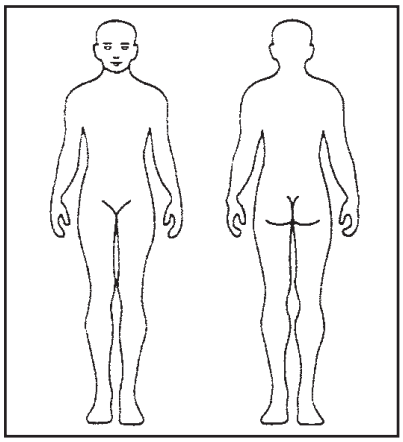
PLEASE LIST 3 OTHER ACTIVITIES THAT THIS PROBLEM STOPS YOU FROM PERFORMING.

_____

_____

_____

ON THE DRAWING BELOW, PLEASE MARK AN **X** AT THE LOCATION OF THIS PROBLEM (S)



PLEASE STATE ANYTHING ELSE YOU FEEL IS IMPORTANT _____

_____

_____

4. HEALTH HISTORY

Height _____ Weight _____ Shoe Size _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

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

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

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

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

5.

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name _____		
Pharmacy Phone (____) _____		