

New Patient Paperwork



Name _____ Today's Date _____
 Birthdate _____ Age _____
 Address _____ City _____
 State _____ Zip _____
 Cell Phone _____ Work Phone _____
 Gender M F Other
 Significant Other's Name _____
 Kid's Names and Ages _____
 Your Employer _____ Type of Work _____
 E-Mail Address _____

Emergency Contact _____ ph # _____
 Relationship to Patient _____
 Name of Family Doctor(s) _____
 Who may we thank for referring you to this office? _____

PRESENT COMPLAINTS

Please Identify the Condition(s) that brought you to this office:

Primary: _____ 2ND: _____
 3RD: _____ 4TH: _____

On a Scale of 1 to 10 with 10 being the worst pain and Zero being no pain, rate your above complaints by **circling** the number:

Primary or Chief Complaint is: 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10
Second Complaint is: 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10
Third Complaint is: 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10
Fourth Complaint is: 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

When did the Problem(s) begin? _____
 When is the problem at its worst? ___AM ___PM ___Mid-Day ___Late PM
 How long does it last? _____
 How did the injury happen? _____

Has this been treated by anyone in the past? **Y/N**

Type of Treatment: _____

Results: _____

Have you Been to a Chiropractor Before? **Y/N**

What was your experience like? _____

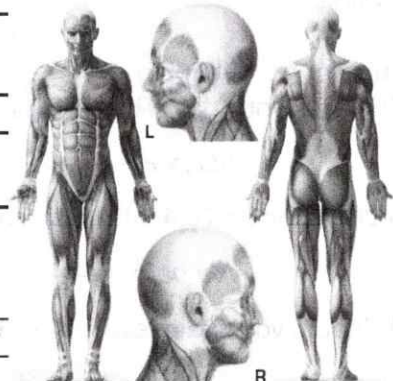
PLEASE **MARK** the areas on the Diagram with the following letters to describe your symptoms:

R= Radiating B= Burning D= Dull A= Aching N= Numbness S= Sharp/Stabbing T= Tingling

What Relieves your Symptoms? _____

What makes your Symptoms worse? _____

ARE YOU PREGNANT? Y/N



Identify any other injury(s) major or minor, the doctor should know about: _____

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climb Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lift Children/Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Read/Concentrate	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Getting Dressed	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Washing/Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sweeping/Vacuumping	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dishes	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Laundry	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Garbage	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

List Prescription & Non-Prescription drugs you take: _____

Quadruple Visual Analogue Scale: If you have more than one complaint, please answer each questions for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example: Headaches Neck Low back
 No pain - 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 - Worst possible pain

1. What is your pain **Right Now**

No pain - 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 - Worst possible pain

2. What is your **Typical or Average pain**

No pain - 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 - Worst possible pain

3. What is your pain level at its **Best** (How close to "0" does your pain get at its best)?

No pain - 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 - Worst possible pain

4. What is your pain level at its **Worst** (How close to "10" does your pain get at its worst)?

No pain - 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 - Worst possible pain

GENERAL HEALTH HISTORY

Patient Name _____ *Mark the conditions that apply to you.*

Past Present

- Headaches
- Migraines
- Shortness of Breath
- Allergies / Asthma
- Medication Side Effects
- Diabetes
- Hands or Feet cold
- Muscle aches
- Trouble Walking
- Leg / Foot Numbness
- Fainting
- ___High or ___Low Blood Pressure
- Ringing in Ears
- Ear Problems
- Sleeping Problems
- Vision Problems
- Thyroid Problems
- Liver Disease
- Kidney Problems
- Light Bothers Eyes
- Other _____

Past Present

- Urinary Problems
- Easy Bruising
- Tobacco Use
- Dental Problems
- Fibromyalgia
- Blood Thinner use
- HIV Positive
- Cancer
- Depression
- Alcohol Use
- Gall Bladder Trouble
- Stroke History
- High Cholesterol
- TMJ Dysfunction
- Digestive Problems
- Pain all Over
- Tension / Irritability
- Chest Pains
- Heart Pacemaker
- Heart Problems

PAST HISTORY

1. List any medications you are taking: _____
2. Please list all doctors you are currently seeing: _____
3. If you have been diagnosed with any of the following conditions, please indicate with a P for in the Past, C for Currently have, or N for Never Had:
___Broken Bone ___Dislocations ___Tumors ___Rheumatoid Arthritis ___Fracture
___Disability ___Cancer ___Heart Attack ___Osteo-Arthritis ___Diabetes
___Cerebral Vascular ___Other Serious Conditions: _____
4. List any past auto collisions: _____ Was any Care Received? _____
5. List any past work injuries: _____ Was any Care Received? _____
6. List any past sport, recreational, or home injuries _____
7. Please describe any past conditions and treatment received: _____
8. Please list any past hospitalizations and surgeries: _____

FAMILY HISTORY

Father's side: Heart Disease Cancer Diabetes Heavy Medication use Arthritis
 Other _____

Mother's side: Heart Disease Cancer Diabetes Heavy Medication use Arthritis
 Other _____

Is there any other family history you want us to know? _____