New Patient Forms

Name_____ Date___/___/___ Age____ Male / Female

Address_____ City_____ State____ ZIP_____

Phone: Home_____ Cell _____ Provider _____

Email Address _____ Date of Birth _____/_____/_____

Occupation _____ Employer's Name _____

Single / Married / Divorced / Widowed Spouse's Name _____

Number of Children _____ Names, Ages & Gender _____

_____

_____

Who may we thank for referring you in? _____ EVAL COST _____

PLEASE LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List Worst First	Rate Severity 1= Mild 10=Unbearable	When did this episode start?	Did you have this condition before? when?	Did the problem begin with an injury**?**	Constant or Intermittent?

Since your problem started, is it

___ ABOUT THE SAME ___GETTING BETTER ___GETTING WORSE

What makes it worse? _____

What helps make it better? _____

Have you seen any other doctors for this condition?

_____Chiropractor _____Medical Doctor _____Other

If so, WHO & WHEN _____

List Surgeries and Date_____

_____

List all MEDICATIONS you are currently taking_____

_____

When was your last Auto Accident? _____

Have you had previous chiropractic care? ____YES ____NO If YES, WHEN &

WHO_____

Have you ever been knocked unconscious? ____YES ____NO

Fractured any bones? ____YES ____NO If YES, Please describe _____

Any other bodily trauma? _____

CIRCLE ANY & ALL OF THESE PROBLEMS YOU'VE HAD IN THE LAST 2 YEARS

DIZZINESS ☐	ASTHMA ☐	KIDNEY PROBLEMS ☐	CHRONIC FATIGUE ☐
HEADACHES ☐	ULCERS ☐	BLADDER PROBLEMS ☐	LUPUS ☐
VERTIGO ☐	CHEST PAINS ☐	IRRITABLE BLADDER ☐	FYBROMYALGIA ☐
EAR INFECTIONS ☐	ARM NUMBNESS ☐	SCIATICA ☐	ADD / ADHD ☐
GRATING OF NECK ☐	ARM PAIN ☐	LEG NUMBNESS ☐	GERD ☐
TMJ ☐	HAND NUMBNESS ☐	FEET NUMBNESS ☐	NERVOUSNESS ☐
NECK PAIN ☐	SHOULDER PAIN ☐	LOW BACK PAIN ☐	EPILEPSY ☐
MIGRAINES ☐	HEART DISORDERS ☐	HIP PAIN ☐	DISC PROBLEMS ☐
STIFFNESS IN NECK ☐	MID BACK PAIN ☐	LEG PAINS ☐	INFERTILITY ☐
CHRONIC SINUS ☐	STOMACH DISORDERS ☐	KNEE PAIN ☐	
THROAT ISSUES ☐	NAUSEA ☐	LIVER DISEASE ☐	OTHER_____
THYROID ISSUES ☐	REFLUX ☐	MENSTRUAL ISSUES ☐	_____
ANXIETY ☐	DEPRESSION ☐	ADDICTION ☐	

CHECK ANY CONDITIONS YOU HAVE CURRENTLY OR IN THE PAST:

STROKE ☐ - CANCER ☐ - HEART DISEASE ☐ - SPINAL SURGERY ☐ - SEIZURES ☐ - SPINAL FRACTURE ☐ - SCOLIOSIS ☐ – DIABETES ☐