

NEW PATIENT INFORMATION

Name _____ SS# _____

Address _____ City _____ State _____ Zip _____

Birth date _____ Age _____ Male _____ Female _____ Marital status _____

By giving the following phone numbers I authorize the use of calls/voicemails

Home Phone _____ Work Phone _____ Cell Phone _____

Occupation _____

Employer _____ Phone _____

Give us your e-mail If you want e-mail appointment reminders and our monthly newsletter

E-mail address _____

PARENT OR SPOUSE INFORMATION

Name _____ SS# _____

Employer _____

How did you find us? Referred by _____ medical doctor, friend, family
 Phone book which? *Yellow book, Dex, Pdc,* Website, Internet, Street Sign Mailer
 Other _____

NEW OR UPDATED AUTHORIZATION FOR TELEPHONE CALLS AND OFFICE MAIL

Federal HIPAA laws allow you to restrict or change the means for the doctor and staff to communication with you or to contact you through alternative means. In order for our office to keep current with changes in addresses or telephone numbers or simply preference choices, we need your permission to contact you via telephone at your work or home, cellular telephone, pager, email, or to leave messages on your answering machine. Your agreement will allow our office to use your name and mailing address for sending reminders about scheduled appointments, re-activation letters, sending birthday/holiday cards, office newsletters, or providing information about other health related matters that may be of interest to you, billing statements/questions, status of your account, and other office related matters. If you have a telephone number that you do not want used for messages or calls, please do not write these numbers on your intake forms. You may indicate a new or preferred mailing address by indicating so on this form. This authorization may be revoked by you, at any time, by advising our office (privacy officer) of this revocation in writing. If you choose not to sign this authorization, this will not have any adverse effect on your treatment, eligibility for benefits, enrollment, or payment.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PROVIDE MY CURRENT INSURANCE INFORMATION

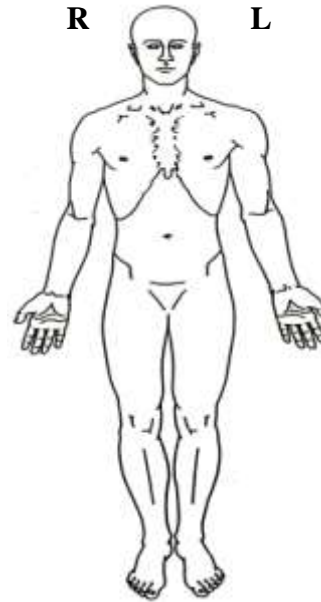
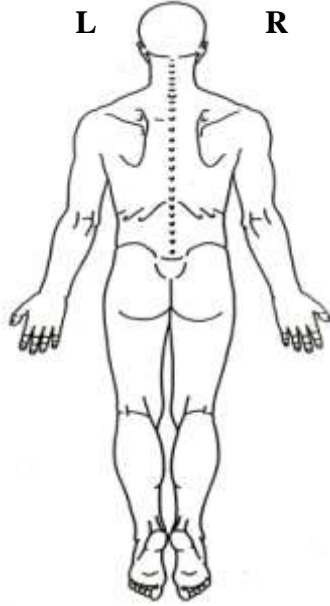
Signature _____ Date _____ No expiration date

Expiration Date/Event for Authorization: Date: _____ Expires When treatment/billing has concluded with our office

NAME _____ Date _____ Age _____ Height _____ Weight _____

1. Describe your main complaint: _____

2. Mark areas of complaints on the body:



2a. Rate your pain: 0=no pain 10 = extreme pain

If Neck Pain or Headaches

What is your neck or headache pain level at its BEST?

0 1 2 3 4 5 6 7 8 9 10

What is your neck or headache pain level at its WORST?

0 1 2 3 4 5 6 7 8 9 10

If Low Back Pain

What is your low back pain level at its BEST?

0 1 2 3 4 5 6 7 8 9 10

What is your low back pain level at its WORST?

0 1 2 3 4 5 6 7 8 9 10

If Mid Back Pain

What is your mid back pain level at its BEST?

0 1 2 3 4 5 6 7 8 9 10

What is your mid back pain level at its WORST?

0 1 2 3 4 5 6 7 8 9 10

Other

Pain at its BEST?

0 1 2 3 4 5 6 7 8 9 10

Pain at its WORST?

0 1 2 3 4 5 6 7 8 9 10

3. What do you think caused your complaint? _____

4. Is this a work related injury? no yes _____

5. **The complaints began:** gradually suddenly
6. **How long has complaint been present?** _____
7. **The pain is:** constant nearly constant comes and goes
8. **What does your main complaint feel like?**
 sharp dull achy throbbing shooting burning pins/needles stiff tight
 other _____
9. **How are your symptoms changing?** getting better getting worse not changing
10. **What makes the PAIN worse?**
 bending forward lifting lying down looking down
 sitting getting up & down standing looking up
 driving activities in general walking turning head
 coughing bending backward cold/damp weather reaching
 sneezing evening morning
 straining at stool other _____
11. **What ACTIVITIES are you having difficulty performing (ie mowing lawn, vacuuming, doing dishes)?**
 nothing

12. **What makes the pain better?**
 ice lying down medication _____
 heat sitting stretching _____
 rest standing other _____
13. **Does the pain radiate?** no
RIGHT upper arm forearm hand buttock thigh calf foot
LEFT upper arm forearm hand buttock thigh calf foot
14. **Is there numbness/tingling?** no
RIGHT upper arm forearm hand buttock thigh calf foot
LEFT upper arm forearm hand buttock thigh calf foot
15. **Is there weakness?** no
RIGHT upper arm forearm hand buttock thigh calf foot
LEFT upper arm forearm hand buttock thigh calf foot
16. **Since the onset of your main complaint have you experienced:**
- | NO | YES | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | unexplained weight loss? |
| <input type="checkbox"/> | <input type="checkbox"/> | loss or changes in bowel or bladder function? |
| <input type="checkbox"/> | <input type="checkbox"/> | chest pain? |
| <input type="checkbox"/> | <input type="checkbox"/> | shortness of breath? |
| <input type="checkbox"/> | <input type="checkbox"/> | nausea and/or vomiting? |
| <input type="checkbox"/> | <input type="checkbox"/> | vision changes? |
| <input type="checkbox"/> | <input type="checkbox"/> | pain is worse during the night? |
| <input type="checkbox"/> | <input type="checkbox"/> | fever and /or rash? |
| <input type="checkbox"/> | <input type="checkbox"/> | sudden severe headache? |

17. **Occupation:** _____ **Are you a shift worker?** no yes

18. **Have you missed work due to these complaints?** no yes

If yes, list dates off work: _____ Have you returned to full duty work? no yes

19. **Have you seen any other physician for THIS complaint?** no one other chiropractor

medical doctor physical therapist other _____

20. **Have you been treated by a physician for ANY condition in the last twelve months?** no yes

Doctor's name _____ Condition? _____

21. **When was your last physical exam?** _____ **Was everything OK?** no yes

22. **Do you have any spinal x-rays?** no yes where were they taken? _____

23. **Are you taking any prescription medications or over the counter drugs?** no yes—if yes,

List medications: _____

24. Present conditions and family history:

Mom	Dad	Self	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis (type? osteoarthritis, rheumatoid arthritis, lupus arthritis, other)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Back Problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bone Fracture (which bone? _____ When? _____)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer (what type? _____)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (type I or type II)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Digestive Disorders (Hiatal Hernia/Acid Reflux/Ulcers)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches (type _____ Diagnosed by MD? <input type="checkbox"/> no <input type="checkbox"/> yes)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple sclerosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis/osteopenia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peripheral Neuropathy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea (Do you use a CPAP? <input type="checkbox"/> no <input type="checkbox"/> yes)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems

List any other condition(s) _____

25. **List any surgeries with dates:** _____

26. **Describe past injuries or falls?** _____

27. **Have you been in any auto accidents?** no yes=when? _____ Were you treated? no yes=
by whom? _____ Did you completely recover? yes no _____

28. **Have you had prior similar complaints?** no yes, describe _____

29. **Is your overall health right now:** Excellent Very Good Good Fair Poor
Do you eat mostly healthy, nutritious food? no yes not sure
Do you eat breakfast? no yes
Do you want to discuss healthy eating and/or weight loss coaching with the doctor? no yes
Do you take vitamins? no yes=what? _____

Has your medical doctor advised you NOT to take certain vitamins? no yes
Do you have a sensitivity to shell fish? no yes **Warning! Glucosamine is made from shell fish!**

30. **Do you smoke or chew tobacco?** no yes=Packs/cans a day? _____

31. **Do you exercise?** rarely occasionally regularly=what type? _____

32. **Do you have a good supportive mattress?** no yes
What is your favorite sleep position? side back stomach

33. **Have you ever been treated by a chiropractor?** no yes If yes, What area was treated?
Low back, mid back, neck. Did the adjustments relieve your symptoms? no yes partially

35. **Marital status:** married-How many dependent children? _____
 single divorced separated widowed

36. **Educational level:** high school graduate vocational school 1 to 4 years of college

37. **(Women only) Are you pregnant?** no YES How many pregnancies have there been? _____
When was your last pap smear? _____ Was it normal? no yes
When was your last mammogram? _____ Was it normal? no yes

38. **(Men only) Have you had a prostate exam?** no yes=when? _____
Were the findings normal? no yes

Signature _____ Doctor reviewed history with patient.

Patient's Name: _____ **Date** _____

Do you drink alcohol? never yes=How many drinks a week? _____

Do you have or have you ever had a dependence on alcohol? no yes

If yes, are you in recovery? no yes

Do you take illegal drugs? no yes

Do you have or have you ever had a dependence on illegal drugs? no yes

If yes, are you in recovery? no yes

Do you have or have you ever had a dependence on prescription drugs? no yes

If yes, are you in recovery? no yes

Do you suffer from any mental disorders? no yes

Are you taking prescription or over the counter medication for your condition? no yes

If yes _____

Do you suffer from depression? no yes

Are you taking prescription or over the counter medication for depression? no yes

If yes _____

Are you receiving counseling for any mental condition? no yes

Do you have AIDs or HIV? no yes

Do you suffer with Post Traumatic Stress Syndrome? no yes

What is the cause? _____

Do you have a communicable disease (such as hepatitis or tuberculosis)? no yes

If yes _____

Other condition: _____

You have the right to restrict the use and disclosure of protected health information particularly the information listed above.

Signed: _____

Check if you don't want information released.