New Patient History

Date _____ Patient's Full Name _____ Age _____ Sex M F

Right/Left Handed Height _____ Weight _____ Occupation _____

Date of injury or onset of symptoms _____ Have you missed work? Yes No if yes, # days lost _____

List complaints/symptoms _____

Describe accident, injury, or illness (if applicable) _____

_____

Have you had the same or similar condition before? Yes No Number of times _____

What makes symptoms worse? _____

What makes symptoms better? _____

Are you getting: □ Better □ Worse □ Same Are your symptoms better in: □ AM □ Midday □ PM □ in bed

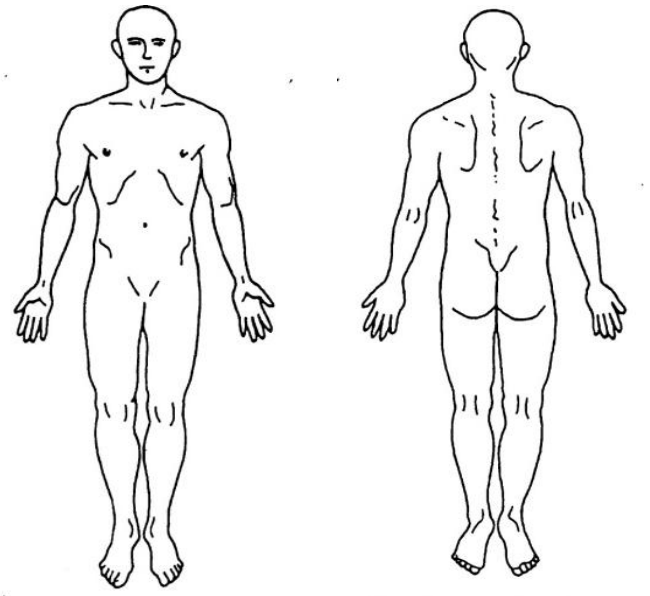
What other doctors/treatments have you tried for this condition? _____

_____

PAIN DRAWING/QUALITY RADIATION **TELL/SHOW US WHERE YOU HURT**

***Please read carefully**: Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below:*

Ache	>>>>>>
	>>>>>>
Burning	xxxxxxx
	xxxxxxx
Numbness	======
	======
Stabbing	////////
	////////
Pins &	+++++++
Needles	+++++++
Throbbing	~~~~~~~
	~~



For Office Use Only
□ 1
□ 4-5
□ >5

Severity of Symptoms: □ □ □ □ □ □ □

Tolerated Annoyance — Interferes w/ activities Do them anyway — Can't do some activities Tolerates some activities — Can't do anything

Visual Analogue Pain Scale: How much pain have you had because of your condition in the past week?

Circle the number which best describes your pain

NO PAIN	0	1	2	3	4	5	6	7	8	9	PAIN AS BAD AS IT COULD BE
		Slight							Severe		

Office Use Only:

_____ cm

Duration / Frequency of Pain: *How much of the day are you in pain?*

□ <25% of Day Intermittent □ 25-50% of Day Occasional □ 50-75% of Day Frequent □ >75% of Day Constant

Average Time in Pain/Day: □ < 1 hour □ 1-4 hours □ 4-8 hours □ Anytime not lying down □ 24 hours

PAST HEALTH HISTORY: *Please list dates and conditions*

Surgeries _____

Injuries/accidents/falls/fractures: _____

_____

Hospitalization: _____

Adult/childhood illnesses: _____

Allergies: _____

Current medications: _____

Family health problems/dysfunction grand/parents/siblings: _____

Date of most recent medical care: _____ Reason: _____

Date of most recent chiropractic care: _____ Reason: _____

Previous diagnostic test, x-rays and results: _____

Previous treatments/other health problems: _____

SYSTEMS REVIEW: *Please mark appropriate box if you have experienced these in the last 12 months*

General: □ Weight change Up or Down □ Weakness/fatigue □ Night sweats □ Fever □ Chills

EENT: □ Tinnitus (ringing ears) Right or Left □ Diplopia (double vision) □ Hearing loss □ Vertigo (whirling) □ Dizziness □ Blurred vision □ Tunnel vision □ Rhinitis (sinus infection/colds) □ Throat hoarseness □ Speech difficulties

Musckel: □ Joint swelling □ Cramps □ Arthritis RA or OA □ Gout Right or Left

CRS: □ Palpitation □ Chest pain □ Cough □ Difficulty breathing □ Hemoptysis (cough up blood)

GI: □ Loss of appetite □ Bowel/bladder problems □ Bloody stool □ Nausea or vomiting

GU: □ Frequency □ Burning □ Hematuria (bloody urine) □ Sexual dysfunction □ Abnormal menses

CNS: □ Headaches □ Seizures □ Fainting spells □ Memory problems □ Pallor/cyanosis □ Sweating □ Reaction to hot/cold

Endo: □ Thyroid (hypo/hyper) □ Diabetes □ Excessive hunger/thirst

Vascular: □ Diabetes □ Anemia □ Temperature changes (hot/cold) □ Color changes (blue/white) □ Arms/hands Right or Left □ Legs/feet Right or Left

Psych: □ Depression □ Nervous □ Anxious □ Irritable/moody □ Crying spells □ Insomnia

PERSONAL/SOCIAL HISTORY:

Exercise you do and how often: _____

Marital status: M S W D Married # _____ times Spouse occupation: _____ Children ages: _____

Parents: □ Married □ Divorced Parents education/occupation: _____

Level of your education: □ Less than High School □ H.S. diploma/GED □ Some College □ College Degree: _____

Description of job: _____

Hobbies: _____

AMOUNT YOU CONSUME:	**None**	**Minimal**	**Moderate**	**Much**
Junk food/fast food:	☐	☐	☐	☐
Sweets, sugar, soda:	☐	☐	☐	☐
Caffeine cups/day: _____	☐	☐	☐	☐
Alcohol drinks/day: _____	☐	☐	☐	☐
Meats, beef, animal fats:	☐	☐	☐	☐
Tobacco packs/day: _____	☐	☐	☐	☐

DIET:

a. Drink enough water (8-12) cups/day)? ☐ Yes ☐ No

b. Eat enough vegetables? ☐ Yes ☐ No

c. Eat raw foods like salad, fruit, etc.? ☐ Yes ☐ No

d. Eat whole grains/flour products? ☐ Yes ☐ No

e. Vitamins: (list) _____

_____

Please indicate below why you are choosing chiropractic care:

□ I want to utilize chiropractic care for the relief of my pain or symptoms only.

□ I want a program designed for a healthy spine and nervous system.

□ I would like the doctor to decide the most appropriate care for me.

Current personal health goals: _____

_____

SIGNED: _____ **DATE:** _____