PATIENT INFORMATION AND HEALTH HISTORY

Date: ________________________ Name: ____

Age: _______________ Date of Birth: ____________ Sex: M F *Preferred Language: ________________________

Address: ______________________________________ City/St: __________________________ Zip: ____________

Home Phone #: ________________________ Cell Phone #: __________________________ E-Mail: ________________________

Marital Status: S M D W Spouse's Name: ___________________________ Children? Y N

If yes, how many? ________________________ Names and Ages: ______________________________________

Emergency Contact: ____ Phone No.: ____________________________

Employed? Y N If yes, Employer's Name: ____

Work Address: ______________________________________ Phone: ____________________________

Occupation: ______________________________________ May we contact you at work, if necessary? Y N

Primary Care Physician: ____

Location: ____ Phone #: __________________________

Who referred you to our office? Patient: ______________________________________ Doctor: ____________________________

Attorney: ______________________________________ Other: ____________________________

For what conditions are you consulting the doctors? ____

Is condition due to: 1. Auto Accident? Y N 2. Work Injury? Y N 3. Other Accident? Y N 4. Illness? Y N

Just Developed? (please explain): ____

Please mark the type of care you desire so that we may be guided by your wishes.

1. Regular care for Health, Maintenance and Prevention: _______ 2. Control of immediate problem: _______

3. Temporary Relief: _______ 4. I prefer the doctors to select the type of care most indicated by my condition: _______

When did symptoms begin? ___________________________________ When was the most recent flare up? ________________________

What do you believe caused the symptoms to appear? ____

Have the symptoms improved? Y N Worsened? Y N Have you had similar symptoms? Y N If yes, when? ______________________________________ Why? ______________________________________

Have you ever been under chiropractic care? Y N If yes, when? ___________________________ Where? ____________________

Who provided treatment? ____________________ Why? ____

Have you had surgery? Y N If yes, when? _________________ Why? ______________________________________

Please list the amounts of the following engaged in daily: Coffee (# of cups) _______ White sugar (# of tsps.) _______ Water (# of glasses) _______
Alcohol (amount weekly) ______________________________________

Average # of sleeping hours: _____ List any regular exercise engaged in: ____

____

Are you currently taking any Medications, Vitamins, or Supplements? (Please include regularly used over the counter medications)

Medication, Vitamins, Supplements Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

PLEASE CHECK ANY SYMPTOMS YOU NOW HAVE

GENERAL

( ) Convulsions
( ) Dizziness or Fainting
( ) Headaches
( ) Numbness

CARDIO-VASCULAR

( ) Rapid Heartbeat
( ) Slow Heartbeat
( ) High Blood Pressure
( ) Low Blood Pressure
( ) Lung Problems
( ) Swelling of Ankles
( ) Poor Circulation
( ) Hardening of Arteries
( ) Rheumatic Fever
( ) Varicose Veins

RESPIRATORY

( ) Chest Pain
( ) Chronic Cough
( ) Difficulty Breathing
( ) Spitting up Blood
( ) Wheezing

GENITO-URINARY

( ) Frequent Urination
( ) Inability to control kidneys
( ) Painful Urination
( ) Discolored Urine
( ) Kidney infection or stones
( ) Prostate Troubles

MUSCLES & JOINTS

( ) Low Back Pain
( ) Leg Pain
( ) Hip Pain
( ) Knee Pain
( ) Foot Trouble
( ) Neck Pain or Stiffness
( ) Shoulder Pain
( ) Arm Pain
( ) Elbow Pain
( ) Hand Pain
( ) Swollen, Stiff, Painful Joints
( ) Arthritis
( ) Broken Bones
( ) Sore or Weak Muscles
( ) Bursitis

GASTRO-INTESTINAL

( ) Poor Appetite
( ) Excessive Appetite
( ) Difficulty Chewing/ Swallowing
( ) Excessive Thirst
( ) Nausea
( ) Vomiting Food
( ) Vomiting Blood
( ) Abdominal Pain
( ) Diarrhea
( ) Constipation
( ) Black or Bloody Stool
( ) Hemorrhoids
( ) Liver Trouble
( ) Gall Bladder Problem
( ) Weight Problem

EYES, EARS, NOSE & THROAT

( ) Asthma
( ) Ear Discharge
( ) Ear Noises
( ) Ear Ache
( ) Ear Pain
( ) Hearing Loss
( ) Nasal Obstruction
( ) Sinus Infection
( ) Nosebleeds
( ) Sore Gums
( ) Dental Problem

SKIN

( ) Bruise Easily
( ) Dryness
( ) Skin Eruptions (Rash)

WOMEN'S HEALTH

( ) Cramps or Backache
( ) Excessive Menstrual Flow
( ) Hot Flashes
( ) Irregular Cycle
( ) Lumps in Breast
( ) Menopausal Symptoms
( ) Painful Menstruation
( ) Vaginal Discharge
( ) Pregnant

Approximate date of last:

Physical Exam: ______ Blood Test: _______ Urine Test: ______ Chest X-Ray: ______ Spinal X-Ray: _______ Dental X-Ray: ______

Family History: List any serious illnesses and/or diseases of family members including grandparents:

____

Mark the condition you have experienced using the letter "M".

Mark the conditions a family member has experienced using the letter "F".

Alcoholism ___ Anemia ____ Appendicitis ____ Cancer ____ Diabetes ____ Eczema ____ Emphysema _____ Foot Problems _____Goiter ____

Gout ____ Heart Disease ____ Ulcers ____ Miscarriage ____ Multiple Sclerosis ____ Rheumatic Fever ____ Stroke ____ Tuberculosis ____

<u>CONSENT FOR PHYSICIAN TO PROCEED WITH TREATMENT</u>

The therapeutic options, treatment plan and potential risks and complications for my conditions have been explained to me. I understand that while the risks of adverse reactions to chiropractic treatment are relatively low when compared to other forms of treatment for similar conditions, unfavorable complications to chiropractic treatment can occur. I understand and acknowledge these risks and I am authorizing the doctors at New Life Chiropractic to proceed with any treatment that may be necessary.

Signature of PATIENT, PARENT OR GUARDIAN: ______________________________Date: ____________

To be completed after you have met with the doctor