# New Patient Information

Welcome to our office! Please complete all questions.

Name:_____ Date:_____
Address:_____ City/State/ZIP:_____
Home Phone#:_____ Cell Phone #:_____ Work Phone #:_____
Birth Date:_____ Age:_____ Social Security #:_____
Marital Status: M W D S Email Address:_____
Your Employer:_____ Occupation:_____
Spouse's Name:_____ Occupation:_____
Children's Names and Ages:_____
Emergency Contact:_____ Phone #:_____

Favorite Hobbies or Interests:_____
_____
_____

Current health complaints/reasons for consulting our office:

1. _____
2. _____
3. _____
4. _____

Is this a result of an auto or work injury?_____ Date of Injury:_____

Were any other passengers involved?_____ Who?_____

Have you lost any days from work?_____

Do you have a copy of the Police Report?_____

Other doctors you have seen for this problem: _____

Surgeries you have had: _____

Medications you currently take: _____

Is there any chance you are pregnant? _____

Have you ever been diagnosed with cancer?_____ If so, what kind? _____

The above information is true and accurate to the best of my knowledge.

Patient or Guardian Signature: _____ Date: _____

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

**CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:**

__Diabetes __Cancer __Heart Disease __Thyroid __Influenza __Eczema
__Anemia __Pleurisy __Arthritis __Epilepsy __Mental Disorders

**INTAKE:**

__Coffee __Tea __Alcohol __Cigarettes __White Sugar

**CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD IN THE PAST SIX MONTHS:**

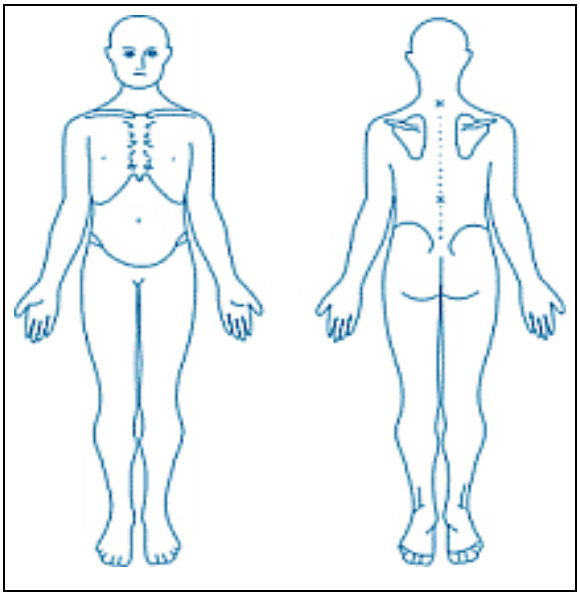
**NERVOUS SYSTEM CODE**

__Nervousness
__Numbness
__Paralysis
__Dizziness
__Forgetfulness
__Confusion/Depression
__Stress
__Fainting
__Weakness
__Convulsions
__Cold/Tingling Extremities

**MUSCULO-SKELETAL CODE**

__Low Back Pain
__Pain between Shoulders
__Neck Pain
__Arm Pain
__Joint Pain/Stiffness
__Walking Problems
__Difficulty with excessive standing
__Difficulty Chewing/Clicking Jaw
__General Stiffness
__Head feels too heavy

Please outline on the diagram the area of your discomfort.



**GASTROINTESTINAL CODE**

__Poor/Excessive Appetite
__Excessive Thirst
__Frequent Nausea
__Vomiting
__Diarrhea
__Constipation
__Hemorrhoids
__Liver Problems
__Heartburn
__Black/Bloody Stool
__Colitis

**C-V-R CODE**

__Chest Pain
__Shortness of Breath
__Blood Pressure Problems
__Irregular Heartbeat
__Heart Problems
__Lung Problems/Congestion
__Varicose Veins
__Ankle Swelling
__Stroke

**GENERAL CODE**

__Fatigue
__Allergies
__Trouble Sleeping
__Fever
__Headaches
__Sinus (after allergies)

**GENITO-URINARY CODE**

__Bladder Trouble
__Discolored Urine

**FEMALES ONLY:**

When was your last menstrual period?
_____

**MALE/FEMALE CODE**

__Menstrual Irregularity
__Gall Bladder Problems
__Weight Trouble
__Abdominal Cramps
__Gas/Bloating after Meals
__Vaginal Pain/Infection
__Breast Pain/Lumps
__Prostate/ Sexual Dysfunction

**WHAT IS YOUR HEALTH PHILOSOPHY?**_____
_____

**HOW DO YOU WANT US TO HANDLE YOUR PROBLEM?**

_____Temporary Relief (Help the symptom but do not fix the cause of the problem)
_____Maximum Correction (Correct the cause of the problem for maximum stability in the future)

**WHY DID YOU COME INTO OUR CLINIC AND WHAT ARE YOUR EXPECTATIONS OF US?**_____
_____

**NAME OTHER DOCTORS YOU HAVE SEEN FOR THIS CONDITION, WHAT WAS DONE, AND FOR HOW LONG**____
_____
_____

**FOR DOCTOR USE ONLY:**

CHIROPRACTIC ANALYSIS:
DIAGNOSIS:
Patient Accepted: ___Yes ___No ___Referred _____
Doctor's Signature