# NEW PATIENT INFORMATION

A/C # ______________

Please check the type of care desired: ( ) Pain Relief Only ( ) Lasting Correction and Prevention

**Date:** ______________ **Language Preference: English ( ) Other:** ______________ **Interpreter (Y) (N)**

Name: ______________________________ ( ) M ( ) F e-mail: ______________________________

Address: __________________________ City: ____________________ State: ____ Zip Code: __________

Cell Phone ( ) __________________ Home Phone: ( ) __________________ OK to leave msg? Y or N

Social Security # ________________ CDL#: ________________ Birthdate: ____________ Age: ________

( ) Married ( ) Single ( ) Other # of Children/ages: ________________ Referred by: ________________

Occupation: ____________________ Employer: ____________________ Work Phone: ( ) __________

Spouse Name (or Parent) ____________________ Spouse's Occupation: ____________________________

**EMERGENCY CONTACT, Relationship and Phone Number:** ______________________________________

Have you ever received Chiropractic care? ( ) Yes ( ) No If so, when? ____________________________

Is this injury work-related or due to an auto accident? ( ) Yes ( ) No

**LOSS OF WELLNESS (Birth - Present)** **Patient Comments**

| Yes | No | | |
|---|---|---|---|
| ( ) | ( ) | Childhood Sickness? | ____________ |
| ( ) | ( ) | Accidents or Falls? | ____________ |
| ( ) | ( ) | Medications/Drugs? | ____________ |
| ( ) | ( ) | Chair pulled out from under you? | ____________ |
| ( ) | ( ) | Did you fall down stairs? | ____________ |
| ( ) | ( ) | Did you have other trauma? What? When? | ____________ |
| ( ) | ( ) | Did/Do you smoke? | ____________ |
| ( ) | ( ) | Did/Do you drink alcohol? | ____________ |
| ( ) | ( ) | Diet (do you eat healthy foods?) | ____________ |
| ( ) | ( ) | Exercise regularly? | ____________ |
| ( ) | ( ) | Sports injuries? | ____________ |
| ( ) | ( ) | Does your jaw pop or click? | ____________ |
| ( ) | ( ) | Other traumas or problems? | ____________ |

Sleeping Posture ( ) Side ( ) Stomach ( ) Back

**SYMPTOMS AND ILL HEALTH**

Present complaints: 1) __________________ 2) __________________ 3) __________________

Doctors seen for these conditions: ______________________________________________

**Other symptoms: (check all that apply)**

| | | | |
|---|---|---|---|
| ( ) Headaches | ( ) Pins & needles in legs | ( ) Fainting | ( ) Neck stiff |
| ( ) Neck Pain | ( ) Pins & needles in arms | ( ) Loss of smell | ( ) Fatigue |
| ( ) Sleeping problems | ( ) Numbness in fingers | ( ) Loss of taste | ( ) Buzzing in ears |
| ( ) Back Pain | ( ) Numbness in toes | ( ) Diarrhea | ( ) Face flushed |
| ( ) Nervousness | ( ) Shortness of breath | ( ) Cold feet | ( ) Ears ring |
| ( ) Tension | ( ) Loss of balance | ( ) Cold hands | ( ) Cold sweats |
| ( ) Irritability | ( ) Loss of memory | ( ) Stomach upset | ( ) Dizziness |
| ( ) Chest Pain | ( ) Lights bother eyes | ( ) Constipation | ( ) Depression |
| ( ) Cancer * | ( ) Heart Attack * | ( ) Stroke * | ( ) Other/specify |

* Please give dates

Women only: Are you currently pregnant? ( ) Yes ( ) No

Current Medications: ______________________________________________

______________________________________________