# New-Patient Information and History

Today's date ______________________

Patient name ______________________ Nickname ____________ Birthdate ____________ Sex: M / F

Address ______________________ City ____________ State ______ ZIP ________

Email ______________________

Cell phone ( ) ____________ Home phone ( ) ____________ Work phone ( ) ____________

Occupation ______________________ Employer ______________________

Insurance co. name ______________________ Subscriber name ______________________

Ins. ID # ____________ Group # ____________ Subscriber birthdate ____________

Spouse name ______________________ Spouse employer ______________________

Emergency contact ____________ Relationship ____________ Contact phone ( ) ____________

Primary care physician (PCP) name ______________________ PCP phone ( ) ____________

**Describe your current problem and how it began:**

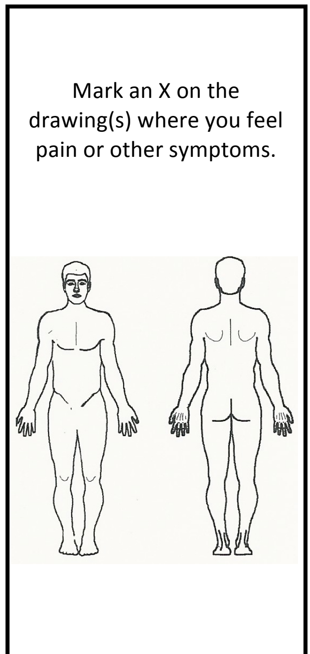
☐ Headache ☐ Neck pain ☐ Mid-back pain ☐ Low-back pain ☐ Other: ____________

Is this: ☐ Work-related? ☐ Auto-accident-related? ☐ Neither

Date problem began: ____________ How problem began: ______________________

Is this a recurrence? ☐ No ☐ Yes – What date did it reoccur? ____________

Mark an X on the drawing(s) where you feel pain or other symptoms.



**Current complaint – How do you feel today?**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No pain | | | | | | | | | | Unbearable pain |

**Describe the pain:** ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Burning ☐ Other: ____________

**In the past week, how much has your pain interfered with your daily activities (for example: work, social activities or household chores)?**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No interference | | | | | | | | | | Unable to carry on any activities |

**What provides relief?** ______________________

**What makes the condition worse?** ______________________

**Have your symptoms gotten worse lately?** ☐ No ☐ Yes – When and how? ____________

**How often are symptoms present?** ☐ 0% to 25% (occasionally) ☐ 26% to 50% ☐ 51% to 75% ☐ 76% to 100% (constantly)

**List any other symptoms related to your primary condition:** ______________________

______________________

______________________

**Have you had a spinal x-ray, MRI or CT scan of your area(s) of complaint?** ☐ No ☐ Yes

Date(s) taken: ____________ Area(s) taken: ______________________

**In general, what would you say your overall health is right now?** ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

**Family history:** ☐ Cancer ☐ Heart problems/Stroke ☐ Diabetes ☐ Rheumatoid arthritis ☐ High blood pressure

**Please check all of the following that apply to you:**

☐ Migraine headaches
☐ Recent fever
☐ Diabetes
☐ High blood pressure
☐ Stroke (date: ______________ )
☐ Visual disturbances
☐ Abnormal weight ☐ loss ☐ gain
☐ Tobacco use – Type: ____________________ Amount: ____________ /day
☐ Prostate problems
☐ Menstrual problems
☐ Urinary problems
☐ Osteoporosis
☐ Arthritis
☐ Epilepsy/Seizures
☐ Dizziness/Fainting
☐ Numbness in groin/buttocks
☐ Morning pain/stiffness
☐ Pain at night
☐ Pain unrelieved by position or rest
☐ Taking birth-control pills
☐ Currently pregnant (# of weeks: ________ )
☐ Alcohol/Drug dependence
☐ Corticosteroid use (Cortisone, Prednisone, etc.)
☐ Cancer/Tumor (explain): ____________________
☐ Surgeries: ____________________
☐ Medications: ____________________
☐ Other health problems (explain): ____________________

**For Office Use Only**

**Please tell us who referred you or how you heard about us:** ____________________

I certify, to the best of my knowledge, the above information is complete and accurate. If the health-plan information is not accurate, or if I am not eligible to receive a healthcare benefit through this practitioner, I understand that I am liable for all charges for services rendered. I agree to notify this practitioner immediately whenever I have changes in my health condition or health-plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed; therefore, I authorize my chiropractor to contact my physician, if necessary.

**Patient signature** ____________________ **Date** ____________