

# NEW PATIENT APPLICATION

**Welcome to our Practice! Please thoroughly complete all questions. Thank you.**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Phone: Home (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Marital status: M/W/D/S Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Social Security #: \_\_\_\_-\_\_\_\_-\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Handedness Right / Left / Ambidextrous

How would you rate your overall Health?  Excellent  Very Good  Good  Fair  Poor

Who may we thank for referring you? \_\_\_\_\_

Have you been to a chiropractor before? Y/N If yes, last time you went \_\_\_\_\_

General Practitioner: \_\_\_\_\_ and City \_\_\_\_\_

Your employer: \_\_\_\_\_

Employer's address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Spouse's name: \_\_\_\_\_

Children's names & ages: \_\_\_\_\_

Do you have health insurance? Y / N Name of company: \_\_\_\_\_

Are you the insured? Y/N If no, who is the insured? \_\_\_\_\_  
If not self, birthdate of insured? \_\_\_\_/\_\_\_\_/\_\_\_\_

Is today's problem caused by:  Auto Accident  Workman's Compensation

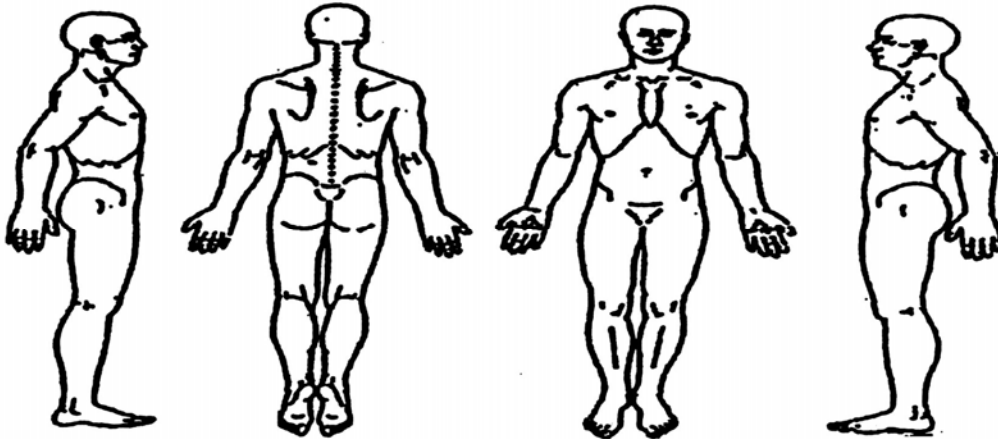
Reasons for consulting our office:

1. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_



Indicate on the drawings below where you have pain/symptoms



How long have you had this/these problem(s)? \_\_\_\_\_

How do you think your problem(s) began? \_\_\_\_\_

Do you consider this problem to be severe?  Yes  Yes, at times  No

How often do you experience your symptoms?

- Constantly (76-100% of the time)  Occasionally (26-50% of the time)  
 Frequently (51-75% of the time)  Intermittently (1-25% of the time)

How would you describe the type of pain?

- Sharp  Numb  Dull  Tingly  Diffuse  
 Achy  Burning  Shooting  Stiff  Other: \_\_\_\_\_

What aggravates your problem? \_\_\_\_\_

How are your symptoms changing with time?

- Getting Worse  Staying the Same  Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

How much has the problem interfered with your work?

- Not at all  A little bit  Moderately  Quite a bit  Extremely

How much has the problem interfered with your social activities?

- Not at all  A little bit  Moderately  Quite a bit  Extremely

Who else have you seen for your problem?

- Chiropractor  Neurologist  Primary Care Physician  
 ER physician  Orthopedist  Other: \_\_\_\_\_  
 Massage Therapist  Physical Therapist  No one

Have you had same or similar problem(s) before? Y / N If yes, how long? \_\_\_\_\_

Indicate if you have any immediate family members with any of the following:

- Rheumatoid Arthritis  Diabetes  Lupus  
 Heart Problems  Cancer  ALS  
 Other \_\_\_\_\_

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

| Past                     | Present                  |                      | Past                     | Present                  |                             | Past                     | Present                  |                         |
|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches            | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure         | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck Pain            | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack                | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Thirst        |
| <input type="checkbox"/> | <input type="checkbox"/> | Upper Back Pain      | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains                 | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination      |
| <input type="checkbox"/> | <input type="checkbox"/> | Mid Back Pain        | <input type="checkbox"/> | <input type="checkbox"/> | Stroke                      | <input type="checkbox"/> | <input type="checkbox"/> | Smoking/Tobacco Use     |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Back Pain        | <input type="checkbox"/> | <input type="checkbox"/> | Angina                      | <input type="checkbox"/> | <input type="checkbox"/> | Drug/Alcohol Dependence |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder Pain        | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Stones               | <input type="checkbox"/> | <input type="checkbox"/> | Allergies               |
| <input type="checkbox"/> | <input type="checkbox"/> | Elbow/Upper Arm Pain | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disorders            | <input type="checkbox"/> | <input type="checkbox"/> | Depression              |
| <input type="checkbox"/> | <input type="checkbox"/> | Wrist Pain           | <input type="checkbox"/> | <input type="checkbox"/> | Bladder Infection           | <input type="checkbox"/> | <input type="checkbox"/> | Systemic Lupus          |
| <input type="checkbox"/> | <input type="checkbox"/> | Hand Pain            | <input type="checkbox"/> | <input type="checkbox"/> | Painful Urination           | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy                |
| <input type="checkbox"/> | <input type="checkbox"/> | Hip Pain             | <input type="checkbox"/> | <input type="checkbox"/> | Loss of Bladder Control     | <input type="checkbox"/> | <input type="checkbox"/> | Dermatitis/Eczema/Rash  |
| <input type="checkbox"/> | <input type="checkbox"/> | Upper Leg Pain       | <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems           | <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS                |
| <input type="checkbox"/> | <input type="checkbox"/> | Knee Pain            | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight Gain/Loss   |                          |                          |                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Ankle/Foot Pain      | <input type="checkbox"/> | <input type="checkbox"/> | Loss of Appetite            |                          |                          |                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw Pain             | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal Pain              |                          |                          |                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint Pain/Stiffness | <input type="checkbox"/> | <input type="checkbox"/> | Ulcer                       |                          |                          |                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis            | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis                   |                          |                          |                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Liver/Gall Bladder Disorder |                          |                          |                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer               | <input type="checkbox"/> | <input type="checkbox"/> | General Fatigue             |                          |                          |                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Tumor                | <input type="checkbox"/> | <input type="checkbox"/> | Muscular Incoordination     |                          |                          |                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma               | <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances         |                          |                          |                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Sinusitis    | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness                   |                          |                          |                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____         |                          |                          |                             |                          |                          |                         |

**For Females Only**  
  Birth Control Pills  
  Hormonal Replacement  
  Pregnancy

List all prescription medications you are currently taking: \_\_\_\_\_

List all of the over-the-counter medications you are currently taking:  
 \_\_\_\_\_

List all surgical procedures you have had:  
 \_\_\_\_\_

What activities do you do at work?

|   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Sit:           | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day    | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand:         | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day    | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day    | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone:  | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |

What activities do you do outside of work?  
 \_\_\_\_\_

Have you ever been hospitalized?  Yes  No

Have you had significant past trauma?  Yes  No

Anything else pertinent to your visit today? \_\_\_\_\_

Females, is there any chance you are pregnant?  Yes  No

The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and the potential for improvement.

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_