



New Patient History Form

Today's Date ___/___/___

PATIENT INFORMATION

CONFIDENTIAL

Thank you for the opportunity to serve you. If you have any questions, do not hesitate to ask. We will be happy to help.

Name, Address, Birth Date, Sex, Status, Employment, Spouse/Parent's Name, etc.

HEALTH HISTORY

Table with 3 columns of symptoms and checkboxes for Past/Present status.

Have YOU (X) or A FAMILY MEMBER (F) ever been diagnosed with any of the following conditions:

Heart Disease, Cancer, Diabetes, High Blood Pressure, Stroke

Blood clotting disorder, Hepatitis, Other

Rate your stress level: Little or No Stress, Minimal Stress, Moderate Stress, Highly Stressed

Do you have any other health concerns or goals that you would like to address? Yes/No If yes, please explain:

Blank lines for patient response to health concerns.

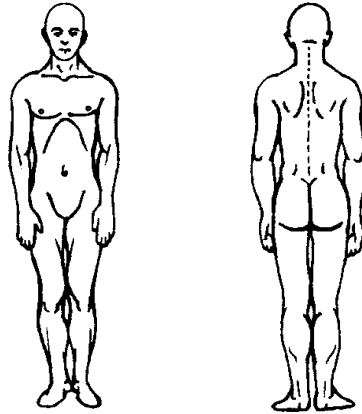
PLEASE LIST YOUR CURRENT AREAS OF COMPLAINT:
(chief complaint)

1) _____ 2) _____ 3) _____ 4) _____
0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10

CIRCLE THE NUMBER THAT BEST DESCRIBES THE INTENSITY OF YOUR PAIN: 1 = Mild, 10 = Severe

PLEASE MARK YOUR AREAS OF COMPLAINT ON THE
BODY DIAGRAM USING THE FOLLOWING KEY:

- Dull = D
- Aching = A
- Stiffness = S
- Burning = B
- Tingling = T
- Numbness = N
- Sharp = !!!
- Shooting = XXX
- Other _____ = ***



When did your symptoms begin? _____

How did your symptoms begin? _____

Is your condition changing? ___ No Change ___ Getting Better ___ Getting Worse

When are your symptoms worse? ___ Morning ___ Afternoon ___ Evening
___ Increase during the day ___ Improve during the day ___ Same All Day

Does anything provide relief? _____

What activities are difficult to perform? Sitting Standing Walking Bending Lying Down Other: _____

How often do you notice your symptoms? (please indicate one)

___ Constantly (76-100%of the day) ___ Frequently (51-75%) ___ Occasionally (26-50%) ___ Intermittently (0-25%)

How much does pain interfere with your normal work? (Work and home)

Not at all A little bit Moderately Quite a bit Extremely

How much of the time has your condition interfered with social activities?

All of the time Most of the time Some of the time A little of the time None of the time

Have you had this problem before? No Yes

When? _____

What treatment did you receive? ___None ___Chiropractic ___Medical ___Physical Therapy ___Massage ___Other_____

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

Have you ever visited a Chiropractor before? No Yes How was your experience? _____

I am currently taking the following medications for the following reasons:

None _____

Surgical History: _____ None

For Women Only: Is there a possibility that you may be pregnant? No Yes

Which best describes your health goals: pain relief only correct entire problem wellness/ preventative care

**Do we have your permission to send you mail? (quarterly newsletter, cards, testimonial form) _____*

DATE: ____ / ____ / ____ SIGNATURE: _____

PARENT/ GUARDIAN: _____