NEW PATIENT INFORMATION

Please print when completing the following questions. Please answer all the questions. If you need help, please ask the receptionist.

Today's Date ____________________________

Name _____________________________________ Date of Birth ________________Social Security No.______________________

Address____ City ____________________ State _____________ Zip ____________

Home Phone #_____________________________________ ◻ Male ◻ Female

Cell Phone # _____________________________________ E-mail ____

◻ Married ◻ Single ◻ Divorced ◻ Widowed Number of children and ages___________________________________

Spouse's Name _____________________________ Date of Birth_______________ Social Security No.______________________

Your Employer ____________________________________ Spouse's Employer _____________________________________

Phone #_____________________ EXT. ________________ Phone_____________________ EXT. _____________________

Occupation____ Occupation ____

Address ____ Address ____

City ________________________ State _____ Zip ________ City ___________________________ State _______ Zip _______

Who is your family physician?____

Have you been treated by a chiropractor before? ◻ Yes ◻ No If yes, who and when?_____________________________________

List your present complaints and describe your symptoms: Date of this injury?____

____

____

____

____

Have you seen other doctors for your present condition? ◻ Yes ◻ No

If yes, how did they treat it and how did you respond?____

Is this a work related injury? ◻ Yes ◻ No

Did you report it to your employer? ◻ Yes ◻ No

Is this an accidental injury? ◻ Yes ◻ No

Auto Accident? ◻ Yes ◻ No

Have you seen an attorney? ◻ Yes ◻ No If yes, who ______________________________ Phone Number ____________________

Please explain:____

____

By signing below, I understand that all charges are payable at the time of the visit. I also understand that charges for x-rays are for analysis, and that they remain the property of Active Health & Wellness Center.

Patient Signature____ Date ______________________________

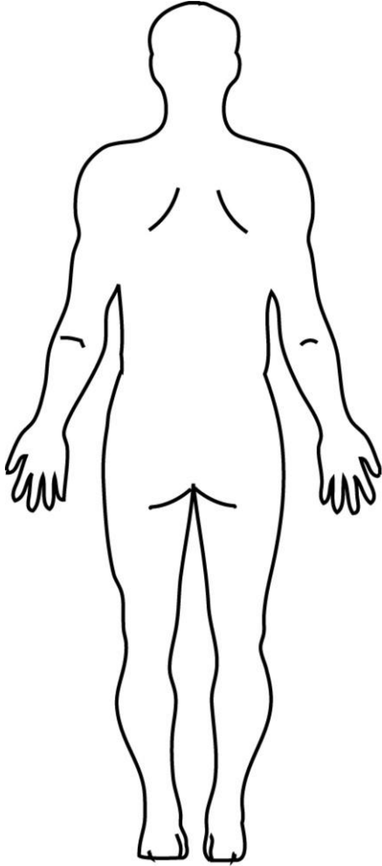
Guardian/Responsible Party's Signature ___________________________________ Date ______________________________

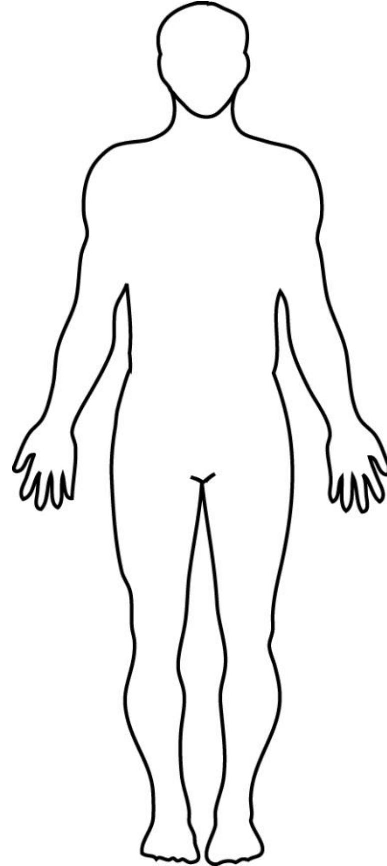
AREAS OF PAIN

Name____ Date____________________

Please indicate the appropriate location of pain and the symbol that best describes the discomfort you are presently experiencing.

Sharp and Stabbing = + + + +
Dull and Achy = v v v v
Pins and Needles = 0 0 0 0
Numbness = / / / /





Patient Signature ____

Please check the appropriate square to describe your present limitations in function:

Activity	Normal	Mildly Limited	Moderately Limited	Severely Limited
Lifting	☐	☐	☐	☐
Bending	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Sitting	☐	☐	☐	☐
Climbing Stairs	☐	☐	☐	☐
Running	☐	☐	☐	☐
Resting in Bed	☐	☐	☐	☐
Intercourse	☐	☐	☐	☐
Other:___________	☐	☐	☐	☐
___________	☐	☐	☐	☐

Patient Name:__________________________________ Account #_______________ Date________________

SYMPTOM SURVEY

(Circle as many as apply)

GENERAL SYMPTOMS:

A) Nervousness B) Irritability C) Fatigue D) Depression
E) Loss of sleep F) Tension G) PMS H) Jaw Pain

HEAD:

A) Headache Mild Moderate Severe
How often (1 2 3 4 5 6) Per day / Wk / Mo
Are They: Sharp Dull
Are They: Constant Intermittent
Where located: Back of Head Forehead
Temples R / L Side
Behind the Eyes

B)Light Headed C)Memory loss D) Fainting
E) Blurred vision D) Double Vision G) Sensitivity to light
H) Loss of Balance I) Hearing loss J) Ringing in ears

NECK:

A) Pain Left side Right side Both
Pain Level: Mild Moderate Severe
Pain is increased by: Forward movement
Backward movement
Rotate head right / left
Bend neck right / left

B) Stiffness C) Muscle Spasm D) Grinding / Grating sounds

SHOULDERS:

A) Pain at joint	Left	Right	Both
B) Pain across shoulder	Left	Right	Both
C) Limitation of Movement	Left	Right	Both
D) Tension	Left	Right	Both

ARMS:

A) Pain in Upper Arm	Left	Right	Both
B) Pain in Elbow	Left	Right	Both
C) Pain in Forearm	Left	Right	Both
D) Pins & Needles (arm)	Left	Right	Both
E) Pins & Needles (forearm)	Left	Right	Both
F) Numbness in Arm	Left	Right	Both
G) Numbness in Forearm	Left	Right	Both

HANDS:

A) Pain in wrist	Left	Right	Both
B) Pain in Hand	Left	Right	Both
C) Pin & Needles (Hand)	Left	Right	Both
D) Numbness (Hand)	Left	Right	Both

MIDBACK:

A) Pain Left Right Both
Pain level: Mild Moderate Severe
Pain Type: Sharp/Stabbing Dull Ache
B) Muscle Spasm Left Right Both

CHEST:

A) Deep Chest Pain Left Right Both
Pain level: Mild Moderate Severe
B) Pain around ribs Left Right Both
C) Shortness of Breath D) Irregular Heartbeat

ABDOMINAL SYMPTOMS:

A) Pain Mild Moderate Severe
B) Nervous Stomach C) Nausea D) Gas E) Constipation
F) Diarrhea G) Heartburn H) Indigestion I) Loss of Appetite

LOWBACK:

A) Upper Lumbar Pain	Left	Right	Both
B) Lower Lumbar Pain	Left	Right	Both
C) Sacro-iliac Pain	Left	Right	Both
D) Muscle Spasm	Left	Right	Both

Pain level: Mild Moderate Severe

HIPS AND LEGS:

A) Pain in Buttocks Left Right Both
Pain level: Mild Moderate Severe
B) Pain in Hip Joint Left Right Both
Pain level: Mild Moderate Severe
C) Pain down Leg Left Right Both
Location: Front Back Side
Pain Radiates to: Knee Calf Foot
D) Numbness down Leg Left Right Both
Location: Front Back Side
E) Pins & Needles (leg) Left Right Both
Location: Front Back Side
F) Knee Pain Left Right Both
G) Leg Cramps Left Right Both

FEET:

A) Ankle	Left	Right	Both
B) Swollen Ankle	Left	Right	Both
C) Foot Pain	Left	Right	Both
D) Numbness of Feet	Left	Right	Both
E) Swollen Feet	Left	Right	Both
F) Cramps	Left	Right	Both

Patient Name:______________________________ Account #______________ Date_______________

EYES
- ☐ Double Vision
- ☐ Glasses
- ☐ Tearing
- ☐ Burning
- ☐ Eye Strain

NOSE
- ☐ Sinusitis
- ☐ Bleeding
- ☐ Post Nasal Drip
- ☐ Obstruction

MUSCULAR
- ☐ Numbness
- ☐ Joint Pain
- ☐ Varicosities
- ☐ Swelling of hands/feet

STOMACH OR INTESTINES
- ☐ Poor Appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Belching
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Rectal Bleeding
- ☐ Irregular Stool
- ☐ Hernia
- ☐ Ulcers

EARS
- ☐ Deafness
- ☐ Discharge
- ☐ Ringing
- ☐ Excess Wax

THROAT
- ☐ Soreness
- ☐ Hoarseness
- ☐ Difficulty Swallowing

URINARY (URINATION)
- ☐ Abnormally Frequent
- ☐ Burning
- ☐ Pain
- ☐ Discolored with Pus/Blood

SKIN
- ☐ Rashes
- ☐ Eruptions
- ☐ Discolorations

HEAD
- ☐ Headaches
- ☐ Trauma
- ☐ Dizziness
- ☐ Fainting

FEMALE (ONLY)
- ☐ Irregular Periods
- ☐ Regular Periods
- ☐ Duration of Periods
- ☐ Number of Pregnancies
- ☐ Complication during pregnancy
- ☐ Menopause

HABITS
- ☐ Coffee
- ☐ Tea
- ☐ Milk
- ☐ Water
- ☐ Fruit Juices
- ☐ Exercise
- ☐ Alcohol
- ☐ Cigarettes
- ☐ Drugs (Pot Etc.)

WEIGHT
- ☐ Gain
- ☐ Loss
- ☐ Hold the same

CHEST
- ☐ Pain
- ☐ Heart Pounding
- ☐ Difficulty Breathing
- ☐ Cough up blood or sputum

FEMALE ONLY: Are you pregnant? _____ yes _____ no __________ Patient Please Initial Here

Please list any medications/prescription drug you are currently taking? Examples: Antibiotics, anti-inflammitories, muscle relaxers, pain meds, sleeping pills, blood pressure meds, diabetic meds, birth control pills, or list others below: ____
____
____

Please list any vitamins/supplements you are currently taking? ______________________________
____
____

DIAGNOSTIC SURVEY

Have you ever been x-rayed before? ______ When/Where ________________________
Area of Body? ______________________ How many times? ____________________

Have you ever had an MRI or CT scan? ______ When/Where ________________________
Area of Body? ______________________ How many times? ____________________

Have you ever had any radiation treatments? ______ When/Where? ________________
Have you ever had any chemotherapy treatments? _____ When/Where? ________________

Patient Name:______________________________ Account #____________ Date______________

HISTORY: INJURIES (AUTO, FRACTURES, ETC.) EXPLAIN_______________________________________

____

____

____

PUT AN "X" N FRONT OF THE FOLLOWING ILLNESSES WHICH YOU HAVE HAD:

- ☐ Measles
- ☐ Mumps
- ☐ Chicken pox
- ☐ Small pox
- ☐ Diphtheria
- ☐ Whooping Cough
- ☐ Polio
- ☐ Scarlet Fever
- ☐ Hay fever
- ☐ Pneumonia
- ☐ Pleurisy
- ☐ Tuberculosis
- ☐ Arthritis
- ☐ Diabetes
- ☐ Goiter
- ☐ Migraine
- ☐ Anemia
- ☐ Fractures
- ☐ Allergies
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Gall Stones
- ☐ Kidney Stones
- ☐ Kidney disease
- ☐ Cancer
- ☐ Meningitis
- ☐ Epilepsy
- ☐ Heart disease
- ☐ Asthma
- ☐ Nervousness
- ☐ Nervous Breakdown
- ☐ "Leaking" heart
- ☐ Rheumatic fever
- ☐ Hepatitis or Jaundice
- ☐ Hives or Eczema
- ☐ any bone or joint
- ☐ Low blood pressure
- ☐ High blood pressure
- ☐ Other

FAMILY HISTORY – PUT AN "X" IN FRONT OF THOSE WHICH APPLY:

	LIVING	DEAD	CANCER	TB	DIABETES	BLOOD DISEASE	ALLERGY	HEART	ARTHRITIS
FATHER									
MOTHER									
SISTERS									
BROTHERS									

PUT THE DATE IN FRONT OF THOSE OPERATIONS WHICH YOU HAVE HAD:

________________ Cholecystectomy (Gall Bladder Operation)
________________ Hernalorraphy (Hernia Operation)
________________ Hemorrhoidectomy (Hemorrhoid Operation)
________________ Hysterectomy (Uterine Operation)
________________ Prostatectomy (Prostate Operation)
________________ Tonsillectomy
________________ Adenoidectomy
________________ Appendectomy
________________ Vaginal Repair
________________ Other Surgery

Patient Name:_________________________________ Account #______________ Date_______________