Welcome to our practice. As a new patient, please complete these forms.

Patient Name _____ Age _____

Chief Complaint _____

History of the problem:

Location _____ Quality _____

(*where is the pain/ problem specifically?) sharp, achy, burning, tingling, throbbing, shooting, etc.

Severity _____ Duration _____

(rate the intensity of the pain on a 1-10 scale with 10 being the worst) what day did it start? Or, if chronic- how long has it been this severe?

Context _____ Timing _____

Where were you/ what were you doing when it started? What activities make it hurt?

Associated Signs/Symptoms _____ Modifying Factors _____

_____ _____

Problems elsewhere that go along with the main problem what makes the problem better or worse?

--- for example, are there headaches/ radiating or referred pains?

Have you had a problem like this before? Y N Have you ever been to a chiropractor before? Y N

When was your last chiropractic visit?_____

Past Medical History – leave blank if you are uncertain.

__ disc bulge/ disc herniation	__ rheumatoid arthritis	__ heart disease	__ alcoholism
__ sciatica	__ arthritis (other than rheumatoid)	__ stroke	__ ulcers
__ thyroid disease	__ drug use	__ Meniere's disease	__ osteoporosis
__ broken/ cracked bones	__ liver disease	__ diabetes	__ allergies
__ migraine headaches	__ gallbladder disease	__ gout	__ asthma
__ frequent/ severe headaches	__ polio or meningitis	__ lupus	__ cancer
__ numbness or tingling	__ blurred or double vision	__ depression	__ tremors or seizures
__ high or low blood pressure	__ kidney disease/ stone	__ sleep apnea	__ HIV/ AIDS or hepatitis
__ neuritis, neuralgia, neuropathy	__ clotting disorder	__ scoliosis	__ multiple sclerosis
__ fibromyalgia	__ full bladder and small amount or urine, or trouble starting		

Anything else you think the chiropractor know about/

__any other disease?_____

Weight_____ maximum weight_____ When was your last visit to an optometrist?_____

Height_____ Date of last dental check-up_____

Have you ever smoked or chewed tobacco?_____ Do you still use tobacco?_____ How much_____

Have you ever been advised to have surgical operation that has not been done? _____

List all medications and supplements _____

_____

List all surgeries/ hospitalizations and the year _____

_____

_____

Any family history of stroke?_____ Have you ever taken birth control pills?_____ Number of pregnancies_____

_____ _____

Signature of Patient Date

Doctor's Review _____ Date_____