New Patient Questionnaire

Patient Information *Patient I.D.* _____

PLEASE PRINT

Name_____ Date_____ SS#_____
Address_____ City_____ State____ Zip_____
Seasonal Address_____ City_____ State____ Zip_____
❑Male ❑Female ● ❑Minor ❑Married ❑Single ❑Widowed ❑Divorced ❑Separated
Birthdate_____ Home Phone_____ Cell_____
Work Phone_____ E-mail Address_____
Employer_____ Occupation_____ #years_____
Business Address_____ City_____ State____ Zip_____
Spouse or Parent's Name_____ Birthdate_____ Phone _____
Emergency Contact_____ Phone _____Relation_____
Whom may we thank for referring you to us? _____
Did you see our Flyer?_____ Newsletter? _____ Other?_____
Name of local primary Physician_____ May we contact them?____

SYMPTOMS

Main Complaint_____ How Bad?_____ How Often?_____
When did it start?_____ Getting Worse?_____ Getting Better?_____
What activity bothers it the most? _____
When is it at its best?_____ When is it at its worst?_____
Rate the pain overall - (0 is pain free - 10 is unbearable pain) 0 1 2 3 4 5 6 7 8 9 10
Other Chiropractors?_____ Positive Experience?____
Other type of physician or therapist?_____ Positive Experience?____
Secondary Complaint_____

Health History - *Please circle all that apply*

AIDS/ HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthritis	Asthma
Bleeding	Breast Lump	Bronchitis	Bulimia	Cancer	Cataracts	Chicken pox
Depression	Diabetes	Emphysema	Epilepsy	Fibromyalgia	Fractures	Glaucoma
Goiter	Gonorrhea	Gout	Heart Diagnosis	Hepatitis	Hernia	Herniated disc
Herpes	Implants	Kidney Diag.	Liver Diagnosis	Measles	Migraines	Miscarriage
Mono	M. S.	Mumps	Osteoporosis	Parkinson's	Polio	Pacemaker
Pneumonia	Prostate	Prosthesis	Rheumatoid	Stroke	Thyroid	Tonsillitis
Tuberculosis	Tumors	Typhoid	Ulcers	V. D.	Whooping Cough	
Chronic Fatigue		High Blood Pressure		High Cholesterol		

Other: _____

Women: How many children?_____ Pregnant?____ Date of last Menstrual Cycle_____
Nursing?_____ Taking Birth Control Pills?_____
Previous Surgeries and Dates? _____
_____
List ALL Medications you are currently taking: _____
_____
What kind of exercise do you do? _____
What supplements do you take?_____
How much do you smoke per day?_____ Drink per week? _____Average # Hours Sleep?_____

*All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize this office to release any information pertaining to my treatment to other health care providers.

Patient Signature_____ **Date**_____