

NEW PATIENT INFORMATION

Patient: _____

Date: _____

Your Personal Information	<p>Name: _____ Spouse: _____</p> <p>Address: _____ City: _____ State: ___ Zip: _____</p> <p>Home Phone: _____ Date of Birth: _____ SS#: _____ - ____ - _____</p> <p>Age: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Marital Status: <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> W <input type="checkbox"/> D</p> <p>Employer: _____ Work Phone: _____</p> <p>Type of Work Performed: _____</p> <p>In Case Of Emergency Notify: _____ Phone #: _____</p> <p>Family Physician: _____ E-mail Address _____</p> <p>Who Should We Thank For Telling You About Our Office? _____</p>
Your Current Health Concern	<p>Primary Reason For Today's Visit: _____</p> <p>Check The Severity Of Your Complaint: (Mild) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (Severe)</p> <p>When Did This Begin? _____ Experienced Previously? <input type="checkbox"/> Yes <input type="checkbox"/> Never</p> <p>Is This Condition: <input type="checkbox"/> Job Related <input type="checkbox"/> Auto Accident <input type="checkbox"/> Fall or Injury <input type="checkbox"/> Other: _____</p> <p>Other Doctors Seen For This Problem: _____</p> <p>Other Doctor's Opinions or Diagnosis: _____</p> <p>Other Or Secondary Health Concerns: _____</p> <p>Drugs Or Medications Now Taking: <input type="checkbox"/> Pain Killers / Muscle Relaxants <input type="checkbox"/> Tranquilizers <input type="checkbox"/> Blood Pressure Medicine <input type="checkbox"/> Antibiotics <input type="checkbox"/> Other: _____</p>
Your Past Health History	<p>Previous Surgeries: <input type="checkbox"/> Eyes / Ears / Nose / Throat <input type="checkbox"/> Head/Neck <input type="checkbox"/> Back /Spine <input type="checkbox"/> Chest / Heart / Lungs <input type="checkbox"/> Abdominal <input type="checkbox"/> Other: _____</p> <p>Previous Fractures Or Broken Bones: <input type="checkbox"/> Yes <input type="checkbox"/> No Describe: _____</p> <p>Previous Falls Or Accidents: <input type="checkbox"/> Yes <input type="checkbox"/> No Describe: _____</p> <p>Previous Hospitalization: <input type="checkbox"/> Yes <input type="checkbox"/> No Describe: _____</p> <p>Previous Chiropractic Care: <input type="checkbox"/> Yes <input type="checkbox"/> No Describe: _____</p> <p>Similar Problem In Family: <input type="checkbox"/> Yes <input type="checkbox"/> No Describe: _____</p> <p>Similar Problems With Co-Workers: <input type="checkbox"/> Yes <input type="checkbox"/> No Describe: _____</p> <p>Do You Workout Or Exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe: _____</p>

PLEASE COMPLETE OTHER SIDE