

# New Patient Information Form

*Date:* \_\_\_\_\_

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Patient Last Name		First Name		M.I.	Ph: cell <input type="checkbox"/> home <input type="checkbox"/>		How did you hear about us: <input type="checkbox"/> Sign <input type="checkbox"/> Yellow pages				
					<input type="checkbox"/> Dr. _____		<input type="checkbox"/> Other _____				
Patient Address			City		State	Zip	Date of Birth (MM/DD/YY)	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F		
Patient SSN		Insured Last Name		First Name		Relationship to Insured: <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> other _____					
Employer Name		Employer Town		Work Phone		Name of person to contact in case of emergency: PH: _____					
Is illness or injury related to: <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Other		Do you have other insurance that might cover this injury/ illness? <input type="checkbox"/> No <input type="checkbox"/> Yes				If yes, please list other insurance company name: Secondary I.D.#: _____					
Please list your reason(s) for this visit. List your condition(s) in order of importance:  1. _____ 2. _____ 3. _____ 4. _____		Approx. date you first noticed:  _____ _____ _____ _____		Using a scale in which "0" is no pain and "10" is severe pain, circle the number that best reflects your condition:  None.....to.....Severe 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				Please check the box that best reflects how much of the time you feel your pain or symptom(s) for the listed reason:  <u>Sometimes</u> <u>Occasionally</u> <u>Frequently</u> <u>Often</u>  <input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 75-100% <input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 75-100% <input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 75-100% <input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 75-100%			

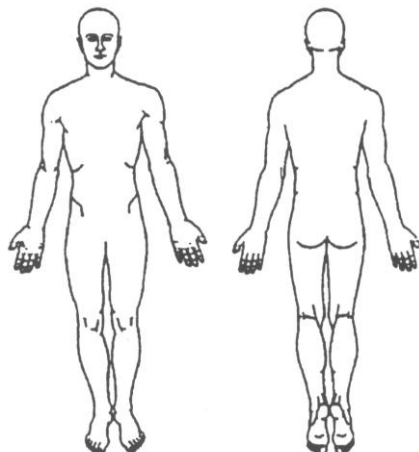
**For each of the reasons or conditions listed above, please mark how it happened:**

1.	<input type="checkbox"/> Developed over time	<input type="checkbox"/> Illness	<input type="checkbox"/> Injury	<input type="checkbox"/> Auto accident	<input type="checkbox"/> Other _____	<input type="checkbox"/> I don't know
2.	<input type="checkbox"/> Developed over time	<input type="checkbox"/> Illness	<input type="checkbox"/> Injury	<input type="checkbox"/> Auto accident	<input type="checkbox"/> Other _____	<input type="checkbox"/> I don't know
3.	<input type="checkbox"/> Developed over time	<input type="checkbox"/> Illness	<input type="checkbox"/> Injury	<input type="checkbox"/> Auto accident	<input type="checkbox"/> Other _____	<input type="checkbox"/> I don't know
4.	<input type="checkbox"/> Developed over time	<input type="checkbox"/> Illness	<input type="checkbox"/> Injury	<input type="checkbox"/> Auto accident	<input type="checkbox"/> Other _____	<input type="checkbox"/> I don't know

**For each reason listed above, please check if it is better or worse with any of the following:**

	HEAT		COLD		REST		ACTIVITY		OTHER (please describe on line below)	
	better	worse	better	worse	better	worse	better	worse	better	worse
Reason 1.	<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"/>	<input type="checkbox"/>
Reason 2.	<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"/>	<input type="checkbox"/>
Reason 3.	<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"/>	<input type="checkbox"/>
Reason 4.	<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"/>	<input type="checkbox"/>

**Please mark the areas of pain or discomfort on the figures using the symbols that best describe the feeling:**



+++ Sharp or stabbing

OOO Pins and needles

VVV Dull or aching

/// Numbness

**Please check the box that best describes whether your pain or symptom(s) limit normal activities:**

<u>Activity</u>	<u>Normal</u>	<u>Somewhat limited</u>	<u>Severely limited</u>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resting in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Computer work/typing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Normal work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Household activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreational activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (list below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

# Chiropractic Patient Information Form

**Please continue...**

- a. During what time of the day do you feel worse?  Morning  Afternoon  Evening  Bedtime  Other [explain] \_\_\_\_\_
- b. Do you generally sleep well?  Yes  No What are your normal sleeping hours? \_\_\_\_\_ to \_\_\_\_\_
- c. Are you currently under the care of a medical doctor or other type of health care provider for any condition?  No  Yes ⇒ For what condition? \_\_\_\_\_ Are you taking any medications?  No  Yes [please list] \_\_\_\_\_
- Name of your medical doctor/provider: \_\_\_\_\_ Phone # ( ) \_\_\_\_\_ - \_\_\_\_\_
- d. Have you ever had an overnight stay in a hospital or a surgical procedure of any kind?  No  Yes If yes, please describe each event below:
- Event \_\_\_\_\_ Year: \_\_\_\_\_
- Event \_\_\_\_\_ Year: \_\_\_\_\_
- e. Do you exercise?  No  Yes If yes, please describe activity: \_\_\_\_\_ How many days a week? \_\_\_\_\_ How many minutes per session? \_\_\_\_ What activities would you like to do, but can't because of your condition? \_\_\_\_\_
- f. (FOR WOMEN)- IS THERE ANY CHANCE THAT YOU MAY BE PREGNANT?  No  Yes

## Personal History

Please read through the list carefully and check the box next to any condition that applies to you.

### Pain in body

- Neck pain with difficulty swallowing
- Extreme neck stiffness with pain or electric shocks in arms or legs when moving neck
- Leg pain that worsens with exercise but is relieved by resting
- Loss of feeling in inner thighs
- Back pain with urinary problems

### Types of pain

- Severe pain interrupts sleep
- Constant pain that doesn't improve by changing positions or lying down

### Current conditions

- Loss of balance when walking

- Recent unexplained weight loss
- Recent progressive muscle weakness or shaking
- Recent or current fever over 102°F
- Loss of bowel or bladder control
- Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
- Recent major accident such as a fall from height, whiplash or blow to the head
- Memory loss after injury
- Night sweats

### Previously diagnosed conditions/medical history

- Rheumatoid arthritis
- Lupus

- Congenital bone or joint disorder
- Gout
- Severe degenerative arthritis
- History of compression fracture
- History of heart attack
- History of stroke or aneurysm
- Past history of cancer or currently diagnosed with cancer
- Diabetes w/ cold, burning or numb feet
- Ankylosing spondylitis
- Immune suppression such as from chemotherapy, organ transplant, etc.
- 3 or more months use of steroid medications or intravenous drugs (past or recent)

## Family History

Please check the box next to each condition that either you or a family have, or have had in the past.

- Autoimmune disorders
- Arthritis
- Cancer
- Diabetes
- Heart Disease
- Kidney Disease
- Mental illness
- Seizure disorder

*I certify that the above information is true and correct to the best of my knowledge. I hereby consent to the release of my confidential medical and patient information in the possession of the Chiropractic Health Centers, LLC to other health professionals to whom I am referred and to the insurance company or other entity responsible for payment, utilization and/or quality review for all or a portion of my care. Additionally, I authorize Dr. McMullen to receive any information acquired by examination or other means that is related to my physical condition, and I hereby release him of any consequence thereof. Furthermore, I assign benefits otherwise payable to me, to the Chiropractic Health Centers, LLC.. I understand that I am financially responsible for any co-pays, deductibles and balance not covered by my insurance.*

Signature \_\_\_\_\_

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_