

# CHIROPRACTIC NEW PATIENT INFORMATION FORM

Page 1 of 2

Please print clearly:

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Apt.# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Shipping Address \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

E-mail address: \_\_\_\_\_

**REFERRED BY:** \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex: M / F

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Marital Status: Married Single Widowed Divorced Name of Spouse: \_\_\_\_\_

Names and Ages of Children: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

---

---

## CHIEF COMPLAINT

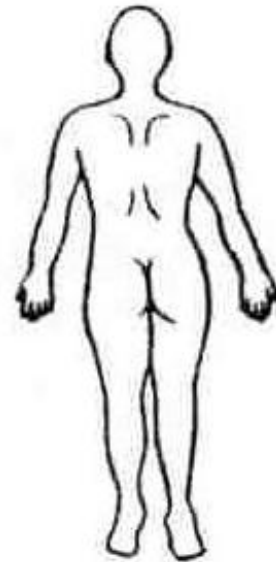
Mark your area of discomfort with the described sensation. Use the appropriate symbols.

Please rate the pain on a scale of 0 to 10 next to each area, with 0 being no pain and 10 being intolerable pain.

XXX Burning (BU)  
----- Numbness (NU)

(((( Aching pain (AC)  
::: Sharp pain (SH)

000 Pins & Needles



**CHIROPRACTIC NEW PATIENT INFORMATION FORM**

**PLEASE DESCRIBE YOUR PAIN OR CONDITION**

Symptoms developed from: Auto Accident Work Related Injury Other \_\_\_\_\_

When did they begin? \_\_\_\_\_

How did it occur? \_\_\_\_\_

What makes your condition better? \_\_\_\_\_ What makes your condition worse? \_\_\_\_\_

Does the pain interfere with your sleep? **Y N** Does the pain get worse at night? **Y N**

Does icing help? **Y N** Does heat help? **Y N** Do you wear a heel lift? **Y N**

Does your pain interfere with work or living habits? **Y N** If so, how? \_\_\_\_\_

**QUESTIONS FOR HEADACHE**

Do you experience:

Nausea or Vomiting? **Y N**

Visual Disturbances? **Y N**

Pain or cracking in jaw? **Y N**

Abnormal blood pressure? **Y N**

**QUESTIONS FOR NECK**

Do you experience:

Difficulty turning your head? **Y N**

Pain or pressure behind eyes? **Y N**

Numbness in hands/fingers? **Y N**

**QUESTIONS FOR LOW BACK**

Do you experience:

Numbness/tingling in feet or legs? **Y N**

Pain down your legs? **Y N**

Changes in bowel or bladder function? **Y N**

Are you currently suffering from any condition other than that for which you are consulting us? If yes, what? \_\_\_\_\_

---

**PAST MEDICAL HISTORY**

Have you ever seen a chiropractor before? **Y N** If so, for what condition? \_\_\_\_\_

Have you had this condition in the past? **Y N** If yes, when? \_\_\_\_\_

Have you previously seen a doctor for the condition you are consulting us about? **Y N** If yes, when? \_\_\_\_\_

Where were you treated? \_\_\_\_\_ By Whom? \_\_\_\_\_

Diagnosis they gave you? \_\_\_\_\_ Results? \_\_\_\_\_

**Patient signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_