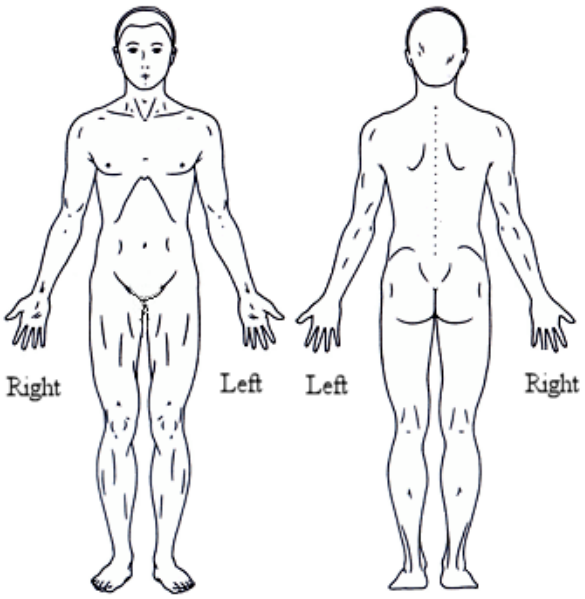
New Patient Intake/History Questionnaire ***ChiroPlus Wellness Care***

Name_____ Date_____
Address_____ State_____ Zip_____
Date of Birth_____ Age_____ Height _____ Weight _____ Blood Pressure _____ / _____
C. Phone (_____) _____H. Phone (_____)_____ W. Phone(_____) _____
E-mail _____Occupation_____
Referred by _____Social Security #_____
Marital Status S M D W Spouse Name_____ Spouses Occupation_____
Number of Children/Ages_____
Do you have health insurance? Yes No If yes, name of the company _____. Please, provide the card for the copy
Have you ever received Chiropractic Care? Yes No
Is your condition(s) result of auto accident or work injury? If yes, provide the date of injury and briefly explain: _____
_____
I am interested in □ Pain relief only □ Corrective & Wellness care □ Acupuncture/Dry Needling □ Nutritional/Metabolic Program

Please circle for each of the following:		Patient Comment If answer is Yes	Doctor's Comments
1. Past History			
Childhood illnesses?	Y N	_____	_____
Ear infections/ Colic/ Asthma?	Y N	_____	_____
Allergies?	Y N	_____	_____
Attention Deficit?	Y N	_____	_____
Antibiotics?	Y N	_____	_____
Drugs, prescription, OTC, recreational?	Y N	_____	_____
Surgery?	Y N	_____	_____
Hospitalizations?	Y N	_____	_____
Sports or other physical activities	Y N	_____	_____
Injuries during sports?	Y N	_____	_____
Auto accidents or work injuries?	Y N	_____	_____
Did you have other traumas?	Y N	_____	_____
Did you ever break any bones?	Y N	_____	_____
2. Current Health Habits:			
Did/do you smoke?	Y N	_____	_____
Did/do you drink alcohol?	Y N	_____	_____
Diet, do you eat healthy foods?	Y N	_____	_____
Have you been in accidents/trauma?	Y N	_____	_____
Have you had surgery?	Y N	_____	_____
Drugs, prescription, OTC, recreational?	Y N	_____	_____
Dental problems?	Y N	_____	_____
Eye problems?	Y N	_____	_____
Hearing problems?	Y N	_____	_____
Exercise regularly?	Y N	_____	_____
Did/do you have occupational stress?	Y N	_____	_____
Drive? Daily time spent driving	Y N	_____	_____
Physical stress?	Y N	_____	_____
Emotional/Mental stress?	Y N	_____	_____
Hobbies/Physical, sports activities?	Y N	_____	_____
Do you sleep well, hours of sleep?	Y N	_____	_____
Significant changes in weight recently?	Y N	_____	_____
Sleeping posture? O side O stomach O back		_____	_____

Symptoms and Present State of Health
Present Complaint/Reason for Seeking Care in this Office:
Major_____
Pain or Problem started on_____
Pains are: O Sharp O Dull/ Ache O Constant O Intermittent O Other_____
Does this pain shoot, radiate, or travel in your body? Where?_____
Are you experiencing numbness or tingling in any area of your body? Where?_____
Since it began, is it: O Same O Better O Worst
What activities aggravate your condition/pain?_____
What activities lessen your condition/pain?_____
Is this condition worse during certain times of the day?_____

Is this condition interfering with Work?_____ Sleep?_____Routine?_____Other?_____
Is this condition progressively getting worse?_____
Other Doctors seen for this condition_____
Any home remedies? _____
Please Circle where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)
Using the symbols below, mark on the pictures where you feel pain.



Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other _____	^ ^ ^

Please mark any of the following conditions or symptoms that you have now or have experienced:
Other Symptoms:

O Headaches	O Pain in Hands or Arms	O Chest Pains
O Neck Pain	O Numbness in Hands or Arms	O Heart Attack
O Sleeping Problems	O Pain in Legs or Feet	O High Blood Pressure
O Low Back Pain	O Numbness in Legs or Feet	O Stroke
O Nervousness	O Fatigue	O Cancer
O Tension	O Depression	O Painful Urination
O Irritability	O Lights Bother Eyes	O Diabetes
O Dizziness	O Loss of Memory	O Diarrhea
O Pain Between Shoulders	O Shoulder Pain	O Constipation
O Neck Stiff	O Sinus	O Stomach Upset
O Joint Swelling	O Shortness of Breath	O Heartburn/Reflux
O Fever	O Asthma	O Weight Loss
O Loss of Balance	O Allergies	O Loss of Smell or Taste
O Ringing in Ears	O Cold Hands	O Menstrual Cramps
O Jaw/TMJ Problems	O Cold Feet	O Menopause

Are you under medical care for any condition?_____
What Medications are you taking?_____
How long?_____ Have you had surgery?_____ What?_____ When?_____
What side effects have you experienced from the drugs and surgery?_____
Females Only – Date last Menstrual Period began on_____ Are you possibly Pregnant?_____

Is there a family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other_____
Father's side	O	O	O	O	O
Mother's side	O	O	O	O	O

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and agree to allow further evaluation. I also understand and agree that all services rendered are directly charged to me and that I am personally responsible for payment. I also understand that upon termination or suspension of my care, any fees for professional services rendered to me will be immediately due and payable. All payments are expected at the time of the visit as fee for service unless specified otherwise. Please, note $35 cancellation fee will be applied when failed to give us 24 hours notice in advance.

Patient Signature_____ Date_____