**New Patient Personal History**

Date \_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_Home Phone ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Driver’s License\_\_\_\_\_\_\_\_\_\_\_\_Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer & Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referred to this office by: Google\_\_ Facebook\_\_ Yellow Pages\_\_ Friend/Family member\_\_**

**Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name of Spouse\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(First) (Middle) (Last)*

Spouse’s Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Social Security#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check One: ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Separated # of Children \_\_\_\_\_\_\_\_\_

Name of Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did you first notice this condition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Has it happened before?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did it appear: ❑ Immediately ❑ Slowly: ( ) weeks ( ) months ( ) years

What aggravates your present condition? ❑ Prolonged Sitting ❑ Standing ❑ Walking

❑ Running ❑ Driving ❑ Other- Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any position relieve the pain?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other doctors seen for this condition?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication taken for this condition?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had previous neck or back injuries? (List date & severity, ie. auto, W/C, trauma, other)\_\_\_\_\_\_\_\_\_\_\_

Job Description & Home Environment (Activities)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your current problem keeping you from doing?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who is responsible for your bill?** ❑ Self ❑ HMO/PPO ❑ Workman’s Comp

❑ Auto Ins. ❑ Medicare ❑ Group Insurance

If **INSURANCE,** please fill in below and present all insurance ID cards.

Primary Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2nd Ins. Co. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grp # \_\_\_\_\_\_\_

Worker’s Comp Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim #\_\_\_\_\_\_\_\_\_\_\_

If **WORK RELATED INJURY**, who did you report the injury to at work?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you made a written report of your injury to your employer? ❑ Yes ❑ No DWC-1 Filed? ❑ Yes ❑ No

**ACCIDENT** Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Comp Auto Accident *(Circle One)*

Your Automobile Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_ Policy/Claim # \_\_\_\_\_\_

Attorney \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone ( ) \_\_\_\_\_\_\_\_\_\_

If this is an accident-related injury, you must fill out the Accident Form. **THANK YOU!**

**Why Chiropractic?** People go to chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wished whenever possible.

❑ Relief Care ❑Corrective Care ❑Check Care ❑ Check here if you want the Doctor to select the type ofcare

desired, that we may be guided by your wishes.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor’s office will prepare any necessary reports and forms to assist me in making collection form the insurance company and that nay amount authorized to be paid directly to the Doctor’s office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the doctor to treat my condition as he deems appropriate through use of manipulation throughout my spine. It is understood and agreed the amount paid the doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

**Patient’s Signature X** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IMPORTANT: Please check (X) all present symptoms

**HEAD:**

❑Headache

* 1. ❑Sinus (allergy)
  2. ❑ Entire head
  3. ❑Back of head
  4. ❑ Forehead
  5. ❑ Temples
  6. ❑ Migraine

❑Head feels heavy

❑Loss of memory

❑ Light-headedness

❑ Fainting

❑Light bothers eyes

❑ Blurred vision

❑ Double Vision

❑Loss of vision

❑Loss of taste

❑Loss of balance

❑ Dizziness

❑Loss of hearing

❑Pain in ears

❑Ringing in ears

❑Bussing in ears

**NECK:**

❑Pain in neck

❑Neck pain with movement

* 1. ❑ Forward
  2. ❑ Backward
  3. ❑Turn to left
  4. ❑ Turn to right
  5. ❑Bend to left
  6. ❑Bend to right

❑Pinched nerve in neck

❑Neck feels out of place

❑Muscle spasms in neck

❑Grinding sounds in neck

❑Popping sounds in neck

❑Arthritis in neck

**SHOULDERS:**

❑Pain in shoulder joint (R-L)

❑Pain across shoulders

❑ Bursitis (R-L)

❑ Arthritis (R-L)

❑Can’t raise arm

* 1. ❑ above shoulder level
  2. ❑ over head

❑Tension in shoulders

❑Pinched nerve in shoulder (R-L)

❑Muscle spasms in shoulders

**ARMS & HANDS:**

❑Pain in upper arm

❑Pain in elbow

❑ Movement aggravated

❑ Tennis elbow

❑Pain in forearm

❑Pain in hands

❑Pain in fingers

❑Sensation of pins/needles in arms

❑Sensation of pins/needles in fingers

❑Numbness in arms (R-L)

❑Numbness in fingers (R-L)

❑Fingers go to sleep

❑ Hands cold

❑Swollen joints in fingers

❑Sore joints in fingers

❑Arthritis in fingers

❑Loss of grip strength

**MID-BACK:**

❑ Mid-back pain

❑ Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑Pain between shoulder blades

❑ Sharp stabbing

❑ Dull ache

❑Pain from front to back

❑ Muscle spasms

❑Pain in kidney area

**CHEST:**

❑ Chest pain

❑Shortness of breath

❑Pain around ribs

❑ Breast pain

❑Dimpled or orange peel breast

❑ Irregular heartbeat

**ABDOMEN:**

❑ Nervous stomach

❑Foods can’t eat \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Nausea

❑ Gas

❑ Constipation

❑ Diarrhea

❑ Hemorrhoids

**LOW BACK:**

❑Low back pain

* 1. ❑ Upper lumbar
  2. ❑ Lower lumbar
  3. ❑ Sacroiliac

❑Low back pain is worse when:

* 1. ❑ Working
  2. ❑ Lifting
  3. ❑ Stooping
  4. ❑ Standing
  5. ❑ Sitting
  6. ❑ Bending
  7. ❑ Coughing
  8. ❑ Lying down (sleeping)
  9. ❑ Walking

❑Pain is relieved when \_\_\_\_\_\_\_\_\_\_\_

❑ Slipped disk

❑Low back feels out of place

❑ Muscle spasms

❑ Arthritis

**HIPS, LEGS & FEET:**

❑Pain in buttocks (R-L)

❑Pain in hip point (R-L)

❑Pain down leg (R-L)

❑Pain down both legs

❑ Knee pain

* 1. ❑ Inside
  2. ❑ Outside

❑ Leg cramps

❑Cramps in feet (R-L)

❑Pins/needles in legs (R-L)

❑Numbness of leg (R-L)

❑Numbness of feet (R-L)

❑Numbness of toes (R-L)

❑Feet feel cold

❑Swollen ankles (R-L)

❑ Swollen feet (R-L)

**MEN ONLY:**

❑ Urinary frequency

❑Difficulty in starting

❑ Night urination

❑ Prostate pain/swelling

**WOMEN ONLY:**

❑Menstrual pain \_\_\_\_\_\_\_\_\_ (where)

❑ Cramping

❑ Irregularity

❑Cycle \_\_\_\_\_\_\_\_\_\_\_ (days)

❑Birth control \_\_\_\_\_\_\_\_\_\_\_\_\_ (type)

❑ Hysterectomy

❑Genital cancer \_\_\_\_\_\_\_\_\_\_\_ (type)

❑ Discharge

❑ Menopause \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Tumors

❑ Abortions

❑Are you or do you think you might be pregnant?

**GENERAL:**

❑ Nervousness

❑ Irritable

❑ Depressed

❑ Fatigue

❑Generally feel run-down

❑Normal sleep \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑Loss of sleep \_\_\_\_\_\_\_\_\_\_ hrs/night

❑Loss of weight \_\_\_\_\_\_\_\_\_\_\_\_\_ lbs.

❑Gain weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ lbs.

❑Coffee \_\_\_\_\_\_\_\_\_ cups/day

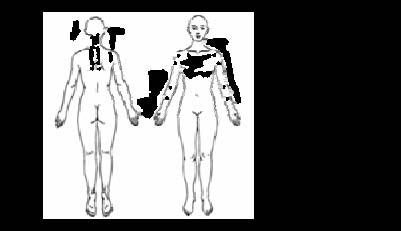
❑Tea \_\_\_\_\_\_\_\_\_\_\_ cups/day

❑Cigarettes \_\_\_\_\_\_\_\_\_\_\_\_ pack/day

❑ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Diabetes

❑ Hypoglycemia



**MEDICAL HISTORY:**

(If any of the following are relevant to your medical history, please check the accompanying box)

❑ Muscle Dystrophy

❑ Rheumatic Fever

❑ Digestive Disorders

❑ Multiple Sclerosis

❑ Sinus Trouble

❑ Convulsions

❑ Backaches

❑ German Measles

❑ Heart Trouble

❑ Dizziness

❑ Diabetes

❑High Blood Pressure

❑ Venereal Disease

❑Pins/needles in legs (R-L)

❑Numbness of leg (R-L)

❑Numbness of feet (R-L)

❑Numbness of toes

❑Feet feel cold

❑Swollen ankles (R-L)

❑ Nervousness

❑ Swollen feet (R-L)

❑ Cancer ❑ Asthma

❑ Polio ❑ Epilepsy

❑ Numbness ❑ Concussion

❑ Scarlet Fever ❑ Arthritis

❑ Tuberculosis ❑ Hepatitis