Welcome to At The Beach Chiropractic Health Center? This is your new patient information packet. Please take the time to read, fill out, and sign the appropriate sections. Please plan to arrive **15 minutes** prior to your scheduled appointment time as this allows us to better take care of your needs. If you wish to cancel or reschedule your appointment please contact our office **24 hours or more in advance.** There is a **$75 administrative fee for missed appointments or for appointments not cancelled 24 hours in advance.** It is our goal to provide each of our patients the best care possible. Please call if you have any questions.

Patients Signature: _____ **Date:** _____

Last Name:_____ **First Name:**_____ **MI:**_____

Date if Birth:_____ **Age:**_____ **Height:**_____ **Weight**_____

Address:_____ **Social Security #:**_____

City:_____ **State:**_____ **Zip Code:**_____

Home Phone:_____ **Cell Phone:**_____ **Email:** _____

Emergency Contact: Name_____ Telphone:_____

Occupation:_____

Which one of our patient's recommended you to our office? _____

List the main problem(s) you are having or the purpose for your consultation:

☐ Low back pain	☐ Neck pain	☐ Fatigue	☐ Osteoporosis
☐ Mid back pain	☐ Headaches	☐ Diabetes	☐ Arthritis
☐ Shoulder pain	☐ Elbow pain	☐ Thyroid disorder	☐ Cancer
☐ Hand/wrist pain	☐ Hip pain	☐ High blood pressure	☐ Acid reflux
☐ Knee pain	☐ Foot/ankle pain	☐ High Cholesterol	☐ Other

Please elaborate on your condition below:

_____

_____

_____

How long ago did your symptoms begin? _____

What types of treatments have you received for your condition? _____

Have any of these treatments been helpful and if so which ones? _____

What makes your symptoms worse (i.e. certain movements, weather changes,etc)? _____

Please describe your pain symptoms:

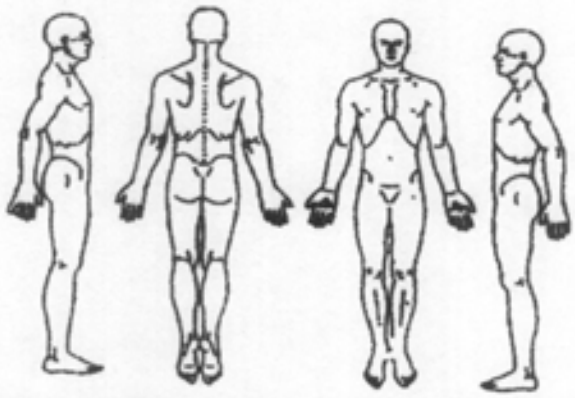
Achy ☐ Sharp ☐ Dull ☐ Burning ☐ Tight ☐ Numb ☐ Stiff ☐
Throbbing ☐ Shooting ☐ Stinging ☐ Stabbing ☐ Other ☐

How often do your symptoms occur?

Constant (all the time) ☐ Frequent ☐ Intermittent ☐

Is it worse in the: A.M. ☐ P.M. ☐ After activity ☐ With movement ☐
Other ☐
Please describe:

Please use the diagram below to demonstrate the location of your pain:



Rate the severity of your pain: No pain 0-1-2-3-4-5-6-7-8-9-10 Severe Pain

Rate your overall health: Poor 0-1-2-3-4-5-6-7-8-9-10 Excellent

Rate your energy levels: Poor 0-1-2-3-4-5-6-7-8-9-10 Excellent

If you could make only one improvement in your health, what would it be?

Symptom Questionnaire: The following questions have been developed to help evaluate your health needs. This process is only as accurate as the information that you provide. If you feel that the topics below do not allow you to verbally express your problem(s), please elaborate during our personal consultation. I would like to remind you that all of this information is strictly confidential unless you state otherwise. If Yes or No does not apply to you then elaborate in the margin.

1. Were you breastfed as a baby? If yes how long?	Yes	No
2. Were you delivered via cesarean section?	Yes	No
3. Have you been through any stressful situations recently?	Yes	No
4. Do you consider yourself to be a person who is easily stressed out?	Yes	No
5. Do you need glasses to read?	Yes	No
6. Do you need glasses to see things at a distance?	Yes	No
7. Do you ever have pain or pressure in your eyes?	Yes	No
8. Are your eyes often red or inflamed?	Yes	No
9. Do your eyes or face often appear puffy?	Yes	No
10. Do your eyelids constantly twitch?	Yes	No
11. Are your eyes often dry and itchy?	Yes	No
12. Do you often have dark circles under your eyes?	Yes	No
13. Do you have to wear sunglasses when outside?	Yes	No
14. Do you find it difficult to drive at night?	Yes	No
15. Do you have trouble seeing clearly in dark lighting?	Yes	No
16. Are your mouth, eyes, or throat chronically dry?	Yes	No
17. Do you frequently have a sour or metallic taste in your mouth?	Yes	No
18. Do you have to wear lip balm regularly to keep your lips from chapping?	Yes	No
19. Do your lips crack and bleed on a regular basis?	Yes	No
20. Do fever blisters or canker sores often bother you?	Yes	No
21. Are you troubled by bleeding gums?	Yes	No
22. Have you lost any of your adult teeth?	Yes	No
23. Do you have a history of dental caries (cavities)?	Yes	No
24. Have you often had severe toothaches?	Yes	No
25. Do you have any dental implants?	Yes	No
26. Do you have any metal fillings?	Yes	No
27. Is your tongue usually badly coated?	Yes	No
28. Do you have chronic halitosis (bad breath)?	Yes	No
29. Have you ever had fluids leaking from your ear?	Yes	No
30. Do you wear a hearing aid?	Yes	No
31. Do you have constant ringing or noises in your ear?	Yes	No
32. Do you get dizzy on a regular basis?	Yes	No
33. Do you have to clear your throat constantly?	Yes	No
34. Have you had your tonsils removed?	Yes	No
35. Are you often troubled with spells of sneezing or allergies?	Yes	No
36. Is your nose continually stuffed up?	Yes	No
37. Are you sensitive to fumes, smoke, perfumes, or other chemical odors?	Yes	No
38. Do you often find it difficult to breathe out of your nose?	Yes	No
39. Do you suffer from a constantly running nose?	Yes	No

40. Have you at times had bad nosebleeds? Yes No
41. Do you ever have spontaneous nosebleeds? Yes No
42. Have you noticed any changes in your ability to taste or smell recently? Yes No
43. Do you suffer from asthma or any other chronic lung disease? Yes No
44. Are you troubled by constant coughing? Yes No
45. Do you get sick more than twice per year? Yes No
46. Have you taken antibiotics recently? Yes No
47. Have you ever had to take antibiotics more than once for a chronic ailment? Yes No
48. Do you suffer from frequent or severe headaches? Yes No
49. Do you often have sinus congestion? Yes No
50. Is your appetite always poor? Yes No
51. Do you usually eat sweets or other foods between meals? Yes No
52. Do you always gulp your food hurriedly? Yes No
53. Do you often suffer from an upset stomach? Yes No
54. Do you usually feel bloated after eating? Yes No
55. Do you usually belch a lot after eating? Yes No
56. Are you often sick to your stomach? Yes No
57. Do you ever suffer from indigestion? Yes No
58. Do you often take medication for heartburn? Yes No
59. Have you ever been diagnosed with stomach ulcers? Yes No
60. Do you suffer from frequent loose bowel movements? Yes No
61. Do you experience gut pain shortly after bowel movements? Yes No
62. Do you have at least one bowel movement per day? Yes No
63. Do you ever experience a burning or itching sensation in the anus? Yes No
64. Have you ever had severe bloody diarrhea? Yes No
65. Is the color of your stool often tan? Yes No
66. Is the color of your stool ever dark black? Yes No
67. Were you ever troubled with intestinal worms or parasites? Yes No
68. Do you constantly suffer from constipation? Yes No
69. Have you ever had piles (rectal hemorrhoids)? Yes No
70. Have you traveled out of the country recently? Yes No
71. Have you ever had jaundice (yellow eyes and skin)? Yes No
72. Have you ever had serious liver or gall bladder trouble? Yes No
73. Do you find it difficult to get to sleep at night? Yes No
74. Do you have difficulty remembering dreams from the night before Yes No
75. Are you bothered by nightmares? Yes No
76. Do you find it impossible to take a regular rest period each day? Yes No
77. Are you exhausted upon waking in the morning? Yes No
78. Do you need coffee to wake up and have energy in the morning? Yes No
79. Are you often exhausted or fatigued? Yes No
80. Do you sleep less than 8 hours a day? Yes No
81. Does every little effort wear you out? Yes No
82. Does nervous exhaustion run in your family? Yes No
83. Are you frequently confined to bed by illness? Yes No
84. Are you always in poor health? Yes No
85. Are you considered a sickly person? Yes No
86. Did you ever have scarlet fever? Yes No
87. As a child, did you have rheumatic fever? Yes No

88. Did you ever have malaria? Yes No
89. Were you ever treated for severe anemia? Yes No
90. Were you ever treated for venereal disease? Yes No
91. Do you have diabetes? Yes No
92. Did a doctor ever say you had a goiter in your neck? Yes No
93. Did a doctor ever treat you for a tumor or cancer? Yes No
94. Do you suffer from any chronic disease? Yes No
95. Did you ever have a serious operation? Yes No
96. Did you ever have a serious injury? Yes No
97. Are your joints often painfully swollen? Yes No
98. Do you have constant muscle aches and pains? Yes No
99. Do your muscles and joints constantly feel stiff? Yes No
100. Have you ever been told that you had arthritis? Yes No
101. Do pains in the back make it hard for you to keep up with your work? Yes No
102. Do muscle cramps or spasms frequently bother you? Yes No
103. Do you have numbness or tingling in any part of your body? Yes No
104. Do your feet ever feel like they burn? Yes No
105. Have you ever had a seizure or convulsion? Yes No
106. Has a doctor ever said your blood pressure was too high? Yes No
107. Has a doctor ever said your blood pressure was too low? Yes No
108. Do you have pains in the heart or chest? Yes No
109. Are you often bothered by thumping of the heart? Yes No
110. Does your heart often race like mad? Yes No
111. Do you often have difficulty with breathing? Yes No
112. Do you run out of breath easily? Yes No
113. Do you sometimes get out of breath just sitting still? Yes No
114. Are your ankles often badly swollen? Yes No
115. Do cold hands or feet trouble you, even in hot weather? Yes No
116. Do you suffer from frequent cramps in your legs? Yes No
117. Has a doctor ever said you had heart trouble? Yes No
118. Does heart trouble run in your family? Yes No
119. Has your cholesterol ever been high? Yes No
120. Do you get up every night to urinate? Yes No
121. During the day, do you usually have to urinate frequently? Yes No
122. Do you often have severe burning when you urinate? Yes No
123. Do you sometimes lose control of your bladder? Yes No
124. Has a doctor ever said you had kidney or bladder disease Yes No
125. Is your memory poor? Yes No
126. Do you have difficulty remembering daily tasks or recent events? Yes No
127. Do your thoughts seem foggy or cloudy? Yes No
128. Do you find it difficult to focus or concentrate on daily activities? Yes No
129. Have you ever been under the care of a psychiatrist? Yes No
130. Does worrying continually get you down? Yes No
131. Do you feel alone and sad at a party? Yes No
132. Do you usually feel unhappy or depressed? Yes No
133. Do you often cry? Yes No
134. Have you ever had a nervous breakdown? Yes No
135. Do you always do things on sudden impulse? Yes No

136. Are you easily upset or irritated? Yes No
137. Do little annoyance get on your nerves and get you angry? Yes No
138. Do people often annoy and irritate you? Yes No
139. Do you often shake or tremble? Yes No
140. Are you constantly keyed up or jittery? Yes No
141. Do sudden noises make you jump or shake? Yes No
142. Do you tremble or feel weak whenever someone shouts at you? Yes No
143. Do frightening thoughts keep coming back in your mind? Yes No
144. Do you often become frightened for no apparent reason? Yes No
145. Do you often break out in a cold sweat? Yes No
146. Does life look entirely hopeless? Yes No
147. Do you often wish you were dead and away from it all? Yes No
148. Do you bruise easily? Yes No
149. Does it take longer than 10 days for a cut or bruise to heal? Yes No
150. Is acne constantly a problem? Yes No
151. Is your skin constantly broken out with bumps? Yes No
152. Do you have to wear lotion to keep your skin from drying out? Yes No
153. Do you break out in rashes on a regular basis? Yes No
154. Is your hair dry and brittle? Yes No
155. Did your hair turn gray prematurely? Yes No
156. Are your finger nails weak or ridged? Yes No
157. Do you have food cravings? Yes No
158. Do you crave ice? Yes No
159. Are you hungry shortly after a meal? Yes No
160. Do you eat out at restaurants frequently? Yes No
161. Do you consume fast food often? Yes No
162. Do you drink soda on a daily basis? Yes No
163. Do you have a history of sexual promiscuity with multiple partners? Yes No
164. Have you ever been diagnosed with a sexually transmitted disease? Yes No
165. Have you ever been a substance abuser? Yes No
166. Have you ever abused alcohol? Yes No
167. Do you drink alcohol on a daily basis? Yes No
168. Do you drink coffee on a daily basis? Yes No
169. Do certain foods make you feel ill? (corn, wheat, dairy) Yes No
170. Do you smoke or use any tobacco products? Yes No
171. Are you constantly exposed to second hand smoke? Yes No
172. Do you consider yourself to be over weight? Yes No
173. Do you consume less than 5 servings of fruits and vegetables per day? Yes No
174. Do you exercise 5 times per week or more? Yes No
175. Does fatigue keep you from exercising? Yes No
176. Is your water intake less than 64 ounces (8 cups) per day? Yes No
177. Do you get less than 2 hours/week direct sunlight without using sunscreen? Yes No
178. Do you consume a lot of foods which contain artificial sweeteners? Yes No

If you experience other symptoms not asked about, please elaborate below:

_____

_____

Past Medical History: please indicate below any health problems you have experienced in the past.

Major Illnesses (Please list dates when conditions were diagnosed):

_____
_____
_____
_____

Accidents or Major Trauma (Please list dates. For scars please give locations):

_____
_____
_____
_____

Surgeries/Hospitalizations (Please list dates):

[ ] Colostomy
[ ] Gastric
[ ] Hemorrhoidectomy
[ ] Bowel (intestinal)
[ ] Other
[ ] Esophageal
[ ] Ileostomy
[ ] Tonsillectomy
[ ] Vasectomy
[ ] Cholecystectomy
[ ] Nephrectomy
[ ] Appendectomy
[ ] Hysterectomy (partial or complete)

_____
_____
_____

Dental Procedures (Root canals, total number of cavities, etc):

_____
_____
_____

Allergies and/or Sensitivities (Drugs, chemicals, foods, environmental):

_____
_____
_____

Occupational Exposures (i.e. mercury, asbestos, etc):

_____
_____
_____
_____

Lifestyle - Check those that apply to you:

[ ] Alcohol (daily weekly monthly)
[ ] Housebound
[ ] Soft drink consumption (____/day)
[ ] Sedentary Job
[ ] Sexually active
[ ] Exercise (none daily weekly monthly)
[ ] Smoker (_____ packs/day)
[ ] Coffee consumption (____ cups/day)
[ ] Fast food consumption (daily weekly monthly)
[ ] Married (yes no divorced)

Women Only: Last Pap-_____ Date of Last menstrual period-_____
Marital History: Years married-_____ # of children-_____ Ages-_____
# of Pregnancies-_____ Deliveries-_____ Complications-_____
Use of Contraceptives?_____ What type?_____
Currently menstruating? _____ Abnormal Pap (HPV, CIN, etc.)?_____
If yes check any of the following symptoms you experience around your periods:
[ ] Heavy bleeding [ ] Painful cramping [ ] Intense mood swings [ ] Bloating
[ ] Food Cravings (sweets, chocolate, etc.) [ ] Headaches [ ] Irregularly timed cycles
[ ] Extreme fatigue [ ] Anxiety [ ] Depression [ ] Breast tenderness
If peri/post-menopausal check any symptoms that you are currently experiencing:
[ ] Hot/cold flashes [ ] Vaginal dryness [ ] Hair loss [ ] Dry skin

Men Only: Date of last prostate exam-_____ Abnormal Prostate findings?-_____
Marital History: Years married-_____ # of children-_____ Rate your job stress (0-10)-_____

Nutritional (diseases, diet, food habit, etc):

[ ] Anorexia
[ ] Fasting (chronic)
[ ] Lactose Intolerance
[ ] Malnutrition
[ ] Salt Intake (high)
[ ] Vegetarian Diet
[ ] Atkins Diet
[ ] Bulimia
[ ] Fiber Intake (high)
[ ] Oxalate Intake (high)
[ ] Protein Intake (high)
[ ] Saturated Fat Intake (high)
[ ] Vegan Diet
[ ] Hollywood Diet
[ ] Carbohydrate Loading
[ ] Food Addictive Intake (high)
[ ] Phytate Intake (high)
[ ] PUFA Intake (high)
[ ] Tannic Acid Intake (high)
[ ] Weight Loss (involuntary)
[ ] South Beach Diet

[ ] Other diet : Please list and describe below.

_____

_____

Nutritional Supplements – Please use the chart below to list all vitamins, minerals, amino acids, or other supplemental products (meal replacement drinks bars, etc.) you are currently taking.

Supplements	Brand	Form	Dose/Frequency	Length of Time
For Example: ***Vitamin E***	***Nature's Made***	***Soft gel cap***	***400 IU/1 X Day***	***6 Months***

Medications – Please list all medications (prescription and over the counter) you are currently taking

Medication	Physician Contact#	Length of time	Dose	Frequency
For Example: ***Ibuprofen***	***OTC***	***1 week***	***400 mg***	***2 X day***

24-Hour Diet Recall: Please list all the foods and beverages you have consumed in the past 24 hours.

BREAKFAST:

_____

LUNCH:

_____

DINNER:

_____

SNACKS:

_____

Family Medical History:

Please give age, lists of any illness, or if deceased.

<u>If deceased, list cause of death and age of death.</u>

Children: _____

_____

_____

Mother: _____

_____

_____

_____

_____

Father: _____

_____

_____

_____

_____

Brothers and Sisters:

_____

_____

_____

_____

_____

_____

Mother's Parents:

_____

_____

_____

_____

_____

_____

Father's Parents: _____

_____

_____

_____

_____

_____

Genetic Ethnic Background/Ancestry (i.e. Irish, Scottish, Middle Eastern, etc.):

_____

_____

_____

<u>Examples:</u>

Arthritis-Type
Genetic Disease - Type
Celiac Disease
Alzheimer's
Allergies
Alcoholism
Asthma
Bleeding Tendency
Cancer-Type
Crohn's Disease
Diabetes-Age at Onset
Drug Abuse
Epilepsy
Gall Bladder
Glaucoma
Heart Disease-Type
High Blood Pressure
Hearing Loss
Hypoglycemia
Kidney Disease
Liver Disease-Type
Osteoporosis
Lupus
Mental Illness- Type
Multiple Sclerosis
Rheumatoid Arthritis
Thyroid Disease
Tuberculosis
Skin Disease-Type
Other Conditions