New Patient Profile

Today's Date____________________ Title Mr. Mrs. Ms. Miss Dr. Prof. Rev.

First Name________________________ Middle Name________________________ Suffix Sr. Jr. III______
Last Name________________________________ Nick Name________________________________
Address 1 ____ SSN _____-_____-__________
Address 2 ________________________________ Male Female Date of Birth ____/_____/_____
A1 City______________ State _______ Zip ________ A2 City______________ State _______ Zip ________
Home Phone (_____) _____ - _________ Work Phone (_____) ____ - _______ Cell Phone (_____) ____ - _______
Home email __________________________________ Work email ____________________________

Email is not optional. If you do not have an email address and/or wish to decline Patient Portal access please sign here ____

Please circle your preferred Method of Contact above. Is it OK to contact you at work? [ ] Yes [ ] No

Employment Status (Please circle) Full time Part time Student Retired Unemployed Disabled Self Employed

Patient Job Title____
Employer/School Name____
Employer/School Address____
City_____________________________ State__________________ Zip__________________________
Employer/School Phone (____) ____ - ______ Fax (____) ____ - ______

Marital Status (Please circle) Single Married Widow/Widower Divorced

Spouse First Name ________________ Middle Name __________________ Last Name _______________
Address 1____________________________________ Address 2_______________________________
City_____________ State _______ Zip ________ City______________ State _______ Zip _________
Spouse Work Phone (_____) _____ - ________ Cell Phone (_____) _____ - ________
Spouse Date of Birth _______/_______/_______ Soc Sec #__________ - _________ - __________

Patient Race

[ ] White [ ] African American [ ] Asian Indian [ ] Native American/Alaskan Native
[ ] Hispanic [ ] Japanese [ ] Vietnamese [ ] Guamanian or Chamorro
[ ] Asia [ ] Chinese [ ] Filipino [ ] Native Hawaiian or Pacific Islander
[ ] Korean [ ] Samoan [ ] Other______________ [ ] I choose not to specify

Multi-racial (please check one) [ ] Yes [ ] No [ ] Unknown or choose not to specify

Ethnicity (please check one) [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] I choose not to specify

Preferred Language (please check one)

[ ] English [ ] Japanese [ ] Russian [ ] Persian [ ] Tagalog [ ] Armenian
[ ] Spanish [ ] French [ ] German [ ] Vietnamese [ ] French Creole [ ] Hindi
[ ] Chinese [ ] Italian [ ] Polish [ ] Portuguese [ ] Gujarati [ ] Urdu
[ ] Korean [ ] Greek [ ] Arabic [ ] AmerSLan [ ] I choose not to specify

Verification Question *(please choose only one question by checking the question, then give the answer to that question)*

[ ] Name of your favorite pet? [ ] City you were born in? [ ] High School you attended?
[ ] Favorite movie? [ ] Mother's maiden name? [ ] Street you grew up on? [ ] Make of first car?
[ ] Your wedding anniversary? [ ] Your favorite color?

Answer to verification question____

(If answer is not at least six characters, please choose a different question)

Patient Name_______________________________________Date_______________________________
Please tell us who referred you to this office, or how you decided to select this office. Please circle.

Family Member	Attorney	Internet Website	Health Class
Friend	Yellow Pages	Billboard	Brochure
Physician	Newspaper Ad	TV commercial	Direct Mail
Employer	Office Sign	Radio	Other____________________

If you selected Family Member, Friend or Physician above, please give their name______________________

____

Emergency Contact Name ___________________________________ Phone (____) _____ - ________

Your Family Physician, or the last doctor you saw as your family physician
Dr. Name________________________ Practice Name_______________ Location_____________
May we contact your family physician listed above to coordinate your care if needed? [ ] Yes [ ] No

Do you use tobacco in any form? [ ] Never [ ] Smoker [ ] Former Smoker [ ] Pipe [ ] Dip/Chew [ ] Cigar
If yes to tobacco, how often do you use tobacco? [ ] Daily [ ] Weekly [ ] Monthly
If yes to tobacco, what is your level of interest in quitting? 0 = No Interest, 10 = Very Interested
Please Circle 0 1 2 3 4 5 6 7 8 9 10
Are you taking prescription medication as prescribed by your medical physician? Yes [ ] No [ ]
Are you taking OTC (over the counter) medication on your own? Yes [ ] No [ ]
Have you received a prescription for additional services from your medical provider? Yes [ ] No [ ]

Please list all current PRESCRIPTION medications, including frequency and dosage and the diagnosis.
If you are taking NO PRESCRIPTION medications, please check the box at the end of this line_____________ [ ]

1. ________________ Dose _______ Freq. ___________ Diagnosis ___________________________
2. ________________ Dose _______ Freq. ___________ Diagnosis ___________________________
3. ________________ Dose _______ Freq. ___________ Diagnosis ___________________________
4. ________________ Dose _______ Freq. ___________ Diagnosis ___________________________
5. ________________ Dose _______ Freq. ___________ Diagnosis ___________________________
6. ________________ Dose _______ Freq. ___________ Diagnosis ___________________________
7. ________________ Dose _______ Freq. ___________ Diagnosis ___________________________
8. ________________ Dose _______ Freq. ___________ Diagnosis ___________________________
9. ________________ Dose _______ Freq. ___________ Diagnosis ___________________________
10. ________________ Dose _______ Freq. ___________ Diagnosis ___________________________
11. ________________ Dose _______ Freq. ___________ Diagnosis ___________________________

List any known MEDICATION allergies
If NO known MEDICATION allergies please check the box at the end of this line_______________________ [ ]

1. _______________Type Reaction_______________ 3. _______________Type Reaction_____________

2. _______________Type Reaction_______________ 4. _______________Type Reaction_____________

Patient Name______________________________________ Date________________________

Instructions
On this history form it is very important that you complete every question. This will allow the doctor to understand your health history and provide better health care. Any unanswered questions will delay your appointment time with the doctor. If you need help answering a question, please ask for assistance.
Please answer all questions truthfully and as accurately as possible. Thank You.

Please check all that apply. Check ONLY those that apply.

Medical Conditions
[ ] Arthritis [ ] Cancer [ ] Diabetes [ ] Heart Disease
[ ] High Blood Pressure [ ] Psychiatric Illness [ ] Skin disorder [ ] Stroke
[ ] Other ____

Surgeries
[ ] Appendectomy [ ] Heart Procedure [ ] Disc Procedure [ ] Hysterectomy
[ ] Joint Replacement [ ] Laminectomy [ ] Prostate Removal [ ] Prostate Surgery

Allergies
[ ] Eggs [ ] Fish & Shellfish [ ] Milk or Lactose [ ] Peanuts
[ ] Soy [ ] Sulfites [ ] Wheat/Gluten

Social History
[ ] caffeine use occasional [ ] caffeine use often [ ] chew tobacco occasional [ ] chew tobacco often
[ ] drink alcohol occasional [ ] drink alcohol often [ ] exercise not at all [ ] exercise occasional
[ ] exercise often [ ] have stress occasional [ ] have stress often [ ] smoke < 1 pack per day
[ ] smoke > 1 pack per day [ ] wear seatbelts always [ ] wear seatbelts never [ ] wear seatbelts usually

Family History
[ ] Arthritis (parent) [ ] Arthritis (sibling) [ ] Cancer (parent) [ ] Cancer (sibling)
[ ] Cholesterol (parent) [ ] Cholesterol (sibling) [ ] Diabetes (parent) [ ] Diabetes (sibling)
[ ] Heart problems (parent) [ ] Heart problems (sibling) [ ] High Blood pressure (parent) [ ] High Blood Pressure (sibling)
[ ] Psychiatric (parent) [ ] Psychiatric (sibling) [ ] Stroke (parent) [ ] Stroke (sibling)
[ ] Thyroid (parent) [ ] Thyroid (sibling)

Substance Use
[ ] Alcohol (past) [ ] Alcohol (present) [ ] Amphetamines (past) [ ] Amphetamines (present)
[ ] Barbiturates (past) [ ] Barbiturates (present) [ ] Cocaine (past) [ ] Cocaine (present)
[ ] Marijuana (past) [ ] Marijuana (present) [ ] Other (past)__________ [ ] Other (present)_____

Male Children
[ ] under 6 years [ ] under 10 years [ ] under 19 years

Female Children
[ ] under 6 years [ ] under 10 years [ ] under 19 years

Occupational Activities
[ ] Administration [ ] Business Owner [ ] Clerical/Secretarial [ ] Computer user
[ ] Construction [ ] Daycare/childcare [ ] Executive/Legal [ ] Food Service
[ ] Healthcare [ ] Heavy equip oper [ ]Heavy manual labor [ ] Home services
[ ] Household [ ] light manual labor [ ] Manufacturing [ ] Medium manual labor
[ ] Military [ ] Police/Fire [ ] Professional Services [ ] Retail Worker
[ ] Teacher [ ] Truck Driver

Recreational Activities
[ ] Backpacking [ ] Biking [ ] Boating [ ] Football
[ ] Golf [ ] Racket Ball [ ] Running [ ] Skiing
[ ] Soccer [ ] Swimming [ ] Tennis [ ] Walking
[ ] Weight Lifting [ ]Other______________________________

Have you had trouble with any of the following:

Cardiovascular: [ ] No to all

	Present	Past	No
Poor Circulation	[ ]	[ ]	[ ]
High Blood Pressure	[ ]	[ ]	[ ]
Aortic Aneurism	[ ]	[ ]	[ ]
Heart Disease	[ ]	[ ]	[ ]
Vascular Disease	[ ]	[ ]	[ ]
Heart Attack	[ ]	[ ]	[ ]
Chest Pain	[ ]	[ ]	[ ]
High Cholesterol	[ ]	[ ]	[ ]
Pace Maker	[ ]	[ ]	[ ]
Jaw/TMJ Pain	[ ]	[ ]	[ ]
Irregular Heartbeat	[ ]	[ ]	[ ]
Swelling of Legs	[ ]	[ ]	[ ]

Genitourinary: [ ] No to all

	Present	Past	No
Kidney Disease	[ ]	[ ]	[ ]
Lower Side Pain	[ ]	[ ]	[ ]
Burning Urination	[ ]	[ ]	[ ]
Frequent Urination	[ ]	[ ]	[ ]
Blood in Urine	[ ]	[ ]	[ ]
Kidney Stones	[ ]	[ ]	[ ]

Hematologic/Lymphatic: [ ] No to all

	Present	Past	No
Hepatitis	[ ]	[ ]	[ ]
Blood Clots	[ ]	[ ]	[ ]
Cancer	[ ]	[ ]	[ ]
Easy Bruising	[ ]	[ ]	[ ]
Easy Bleeding	[ ]	[ ]	[ ]
Fever/Chills/Sweats	[ ]	[ ]	[ ]

Psychiatric: [ ] No to all

	Present	Past	No
Depression	[ ]	[ ]	[ ]
Anxiety Disorder	[ ]	[ ]	[ ]
Unusual Stress	[ ]	[ ]	[ ]

Respiratory: [ ] No to all

	Present	Past	No
Asthma	[ ]	[ ]	[ ]
Tuberculosis	[ ]	[ ]	[ ]
Shortness of Breath	[ ]	[ ]	[ ]
Emphysema	[ ]	[ ]	[ ]
Colds/Flu	[ ]	[ ]	[ ]
Cough/Wheezing	[ ]	[ ]	[ ]

Ears/Nose/Throat [ ] No to all

	Present	Past	No
Dizziness	[ ]	[ ]	[ ]
Hearing Loss	[ ]	[ ]	[ ]
Sinus Infection	[ ]	[ ]	[ ]
Nose Bleeds	[ ]	[ ]	[ ]
Sore Throat	[ ]	[ ]	[ ]
Difficulty Swallowing	[ ]	[ ]	[ ]
Bleeding Gums	[ ]	[ ]	[ ]

Eyes: [ ] No to all

	Present	Past	No
Glaucoma	[ ]	[ ]	[ ]
Double Vision	[ ]	[ ]	[ ]
Blurred Vision	[ ]	[ ]	[ ]

Integumentary: [ ] No to all

	Present	Past	No
Skin Lesions	[ ]	[ ]	[ ]
Skin Ulcers	[ ]	[ ]	[ ]
Skin Disease	[ ]	[ ]	[ ]
Eczema	[ ]	[ ]	[ ]
Psoriasis	[ ]	[ ]	[ ]
Rashes	[ ]	[ ]	[ ]

Constitutional: [ ] No to all

	Present	Past	No
Weight Loss or Gain	[ ]	[ ]	[ ]
Energy Level Problem	[ ]	[ ]	[ ]
Difficulty Sleeping	[ ]	[ ]	[ ]

Allergic/immunological: [ ] No to all

	Present	Past	No
Hives	[ ]	[ ]	[ ]
Immune Disorder	[ ]	[ ]	[ ]
HIV/AIDS	[ ]	[ ]	[ ]
Allergy Shots	[ ]	[ ]	[ ]
Cortisone Use	[ ]	[ ]	[ ]

Gastrointestinal: [ ] No to all

	Present	Past	No
Gall Bladder Problems	[ ]	[ ]	[ ]
Bowel Problems	[ ]	[ ]	[ ]
Constipation	[ ]	[ ]	[ ]
Liver Problems	[ ]	[ ]	[ ]
Ulcers	[ ]	[ ]	[ ]
Diarrhea	[ ]	[ ]	[ ]
Nausea/Vomiting	[ ]	[ ]	[ ]
Bloody Stools	[ ]	[ ]	[ ]
Poor Appetite	[ ]	[ ]	[ ]

Musculoskeletal: [ ] No to all

	Present	Past	No
Gout	[ ]	[ ]	[ ]
Arthritis	[ ]	[ ]	[ ]
Joint Stiffness	[ ]	[ ]	[ ]
Muscle Weakness	[ ]	[ ]	[ ]
Osteoporosis	[ ]	[ ]	[ ]
Broken Bones	[ ]	[ ]	[ ]
Joint Replacement	[ ]	[ ]	[ ]

Endocrine: [ ] No to all

	Present	Past	No
Thyroid Disease	[ ]	[ ]	[ ]
Diabetes	[ ]	[ ]	[ ]
Hair Loss	[ ]	[ ]	[ ]
Menopause	[ ]	[ ]	[ ]
Menstrual Problems	[ ]	[ ]	[ ]

Neurological: [ ] No to all

	Present	Past	No
Babinski	[ ]	[ ]	[ ]
Stroke	[ ]	[ ]	[ ]
Seizures	[ ]	[ ]	[ ]
Head Injury	[ ]	[ ]	[ ]
Brain Aneurysm	[ ]	[ ]	[ ]
Numbness	[ ]	[ ]	[ ]
Severe Headaches	[ ]	[ ]	[ ]
Pinched Nerves	[ ]	[ ]	[ ]
Parkinsons Disease	[ ]	[ ]	[ ]
Carpal Tunnel	[ ]	[ ]	[ ]
Spinning/Balance Issues	[ ]	[ ]	[ ]

Patient Name____ Date______________________________

Subjective : Please mark the following drawing showing where your pain is

L R L R R L

Please select the level of your pain TODAY

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain Possible

Please describe the problem you would like for us to address today. ______________________________

____

When did your symptoms start? (Please give a date if possible)______________________________

How did your symptoms begin? (Please describe any accident or injury)______________________________

____

What percent of the day do you experience your symptoms?

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

What describes the nature of your symptoms? [ ] Sharp [ ] Dull Ache [ ] Numb [ ] Shooting [ ] Burning [ ] Tingling

How are your symptoms changing? [ ] Getting Better [ ] Not changing [ ] Getting Worse

During the past four weeks, indicate the average intensity of your symptoms

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain Possible

Patient Name____ Date____________________________

During the past four weeks, how much has your pain interfered with your normal job/work and household chores
[ ] Not at all [ ] A little bit [ ] Moderately [ ] Quite a bit [ ] Extremely

During the past four weeks how much of the time has your condition interfered with your social activities?
[ ] All the time [ ] Most of the time [ ] Some of the time [ ] A little of the time [ ] None of the time

In general would you say that your overall health right now is ...
[ ] Excellent [ ] Very Good [ ] Good [ ] Fair [ ] Poor

Who else have you seen for this problem?
[ ] No one [ ] Other Chiropractor [ ] Medical Doctor [ ] Physical Therapist [ ] Other ____________________

What treatment, if any, did you receive for your symptoms? [ ] None
[ ] Adjustments [ ] Physical Therapy [ ] Medication [ ] Surgery [ ] Surgery [ ] Other____________________

When did you receive this treatment? [ ] N/A [ ] in the last month [ ] 2-3 months ago [ ] 3-6 months ago
[ ] 6 months–1 year ago [ ] 1-2 years ago [ ] 2-5 years ago [ ] 5-10 years ago [ ] More than 10 years ago
Give a specific date if possible____

What tests have you had for your symptoms? [ ] None
[ ] X-Rays [ ] MRI [ ] CT Scan [ ] Other ____

When were these tests done? [ ] N/A [ ] In the last month [ ] 2-3 mos ago [ ] 3-6 mos ago [ ] 6 mos-1 year ago
[ ] 1-2 years ago [ ] 2-5 years ago [ ] 5-10 years ago [ ] more than 10 years ago

Have you had similar symptoms in the past? [ ] Yes [ ] No

If you have received treatment in the past for the same symptoms, who did you see? [ ] No one [ ] This office
[ ] Another Chiropractor [ ] Medical Doctor [ ] Physical Therapist [ ] Other ____________________

What is your occupation? [ ] Professional/Executive [ ] White Collar/Secretarial [ ] Tradesperson
[ ] Skilled Laborer [ ] Unskilled Laborer [ ] Homemaker [ ] Full-Time Student [ ] Part-Time Student
[ ] Retired [ ] Disabled [ ] Unemployed Other____

If you are employed, are you [ ] Full-Time [ ] Part-Time [ ] Self-Employed [ ] Currently Off Work

WHAT makes the problem worse ____

____

WHAT makes the problem better? ____

____

Please select as many words to describe your pain as you need:

Dull	Sharp	Sharp with movement	Throbbing	Burning	Deep
Aching	Tingling	Stabbing	Cramping		Numb