ADULT HEALTH FORM (New Patient Form)

Today's Date: __________ Name: ____ SS #: ________________________

Home #: (   )________________ Cell #: (   )__________________ Work #: (   )__________________

Address: ____City: _________________ State: ____ Zip: ________

E-mail Address: ____ Date of Birth: __________ Age: _____ Sex: M F

Occupation: ____ Employer: _______________________________________
Employer's Address: ____ Yrs. Employed: __________
Marital Status: **S M D W** Spouse's Name: ___________________________________ Spouse's Date of Birth: _______
Primary Care Physician: ____ PCP Clinic: ____________________________
Y N Do you have any children? How many? ______ How did you hear about our office? ___________________

Who is responsible for the account/payment? **Self Spouse Parent Other**: ___________________________________
Name: ____ Ph: ______________________ Date of Birth: ____________

Who should we contact in case of emergency? _________________________Relationship: ___________ Ph: ___________

Reason for today's visit? Be specific w/ location: ____
When and how did it start? ____
Y N Work-related injury? **Y N** Auto accident? **Y N** Injury at home? **Y N** Injury Elsewhere? _______________
Did it begin gradually or suddenly? _____________ Has it been getting worse, better or the same? ________________
What activities make your symptoms better? ____
What activities make your symptoms worse? ____
Describe your pain: **Dull Sharp Burning Numbness Sore Stiff Tight Achy Throbbing Other**: _________
Y N Does your pain radiate to another part of your body? If yes, where? _______________________________
How would you describe the pain intensity? **Rate: (Mild) 0 1 2 3 4 5 6 7 8 9 10 (Severe)**
Does your pain come and go or is it constant? **Constant Come & Go**
Y N Have you tried home remedies? If yes, what were they? ____
List doctors seen and tests done for your condition? ____
Y N Have you ever had anything like this before? Describe: ____
Y N Have there been any other changes in any body function? Describe: _________________________________
Y N Has your condition affected your daily activities in any way? Describe: ____________________________
Y N Have you been unable to work because of your current problem?

HEALTH HISTORY:
Y N Have you ever been to a chiropractor before? Whom? ____
List any medications you are taking: ____
List any surgeries and the date you had them: ____
Y N Have you been diagnosed with any other conditions? Describe: _____________________________________
Y N Have you broken any bones? List here: ____
Y N Have you ever had significant falls, work injuries or auto accidents in the past? Describe:

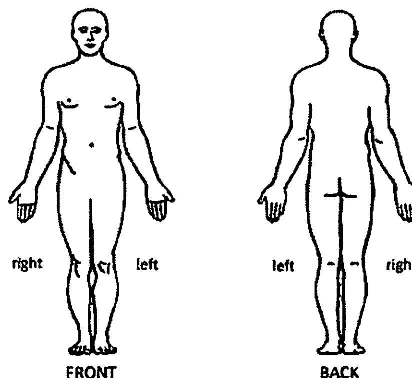
____

FAMILY HISTORY:

MOTHER	___ Diabetes	___ Heart	___ Kidney	___ Cancer	___ Back Pain	___ Stroke
FATHER	___ Diabetes	___ Heart	___ Kidney	___ Cancer	___ Back Pain	___ Stroke
BROTHER	___ Diabetes	___ Heart	___ Kidney	___ Cancer	___ Back Pain	___ Stroke
SISTER	___ Diabetes	___ Heart	___ Kidney	___ Cancer	___ Back Pain	___ Stroke

DISCOMFORT AREAS:
Shade and code areas to indicated
Location of pain or discomfort

USE CODES:
P = Pain
S = Spasm
N = Numbness
T = Tenderness



WOMEN:
Are you pregnant? **Y N Unsure/Possibly**
What was the first day of your last menstrual cycle?
(Date): ______________________________

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

___ Aids	___ Malaria	___ Chicken Pox	___ Alcoholism	___ Appendicitis	___ Tuberculosis
___ Diabetes	___ Venereal Infection	___ Scarlet Fever	___ Substance Abuse	___ Cancer	___ Arthritis
___ Diphtheria	___ Anemia	___ Heart Disease	___ Epilepsy	___ Typhoid Fever	___ Measles
___ Goiter	___ Mental Disorder	___ Pneumonia	___ Mumps	___ Influenza	___ Whooping Cough
___ Rheumatic Fever	___ Small Pox	___ Pleurisy	___ Eczema	___ Polio	Other:___________

CHECK ANY OF THE FOLLOWING PROBLEMS YOU HAVE OR HAVE HAD IN THE PAST 6 MONTHS:

Muscles & Joints
___ Low Back Pain
___ Pain Between Shoulders
___ Neck Pain/Stiffness
___ Arm/Elbow/Wrist Pain
___ Walking Problems
___ Difficulty Chewing
___ Clicking Jaw
___ Leg/Knee/Foot Pain
___ Hip Pain
___ Pain in Tailbone

Nervous System
___ Nervousness
___ Numbness
___ Paralysis
___ Dizziness
___ Confusion
___ Depression
___ Fainting
___ Convulsions

Eye, Ear, Nose & Throat
___ Vision Problems
___ Dental Problems
___ Sore Throat
___ Earaches
___ Hearing Difficulty
___ Stuffed Nose
___ Ringing in the Ears
___ Nose Bleeds
___ Sinus Trouble
___ Swollen Glands

General Problems
___ Fatigue
___ Night Sweats
___ Frequent Colds
___ Loss of Sleep
___ Fever
___ Headaches
___ Weakness

Stomach/Intestines
___ Poor Appetite
___ Excessive Appetite
___ Excessive Thirst
___ Nausea
___ Vomiting
___ Diarrhea
___ Hemorrhoids/Piles
___ Liver Trouble
___ Gall Bladder Problems
___ Weight Trouble
___ Stomach Cramps
___ Stomach Pain
___ Gas/Bloating
___ Heartburn
___ Black/Bloody Stool
___ Colitis
___ Poor Digestion

Allergies
___ Seasonal __________
___ Allergic Reactions to: ______________________

Men
___ Prostate Pain
___ Impotence
___ Infertility

Women
___ Menses Irregular
___ Menstrual Cramps
___ Vaginal Pain
___ Breast Lumps
___ Pain During Sex
___ Difficulty Getting Pregnant
___ Miscarriage

Habits
___ Smoking – Packs/Day ____
___ Alcohol – Drinks/Day ____
___ Coffee – Cups/Day ____
___ Soda – Cans/Day ____
___ Fast Food – Meals/Wk ___

Patient's Signature: ______________________________ ***Date:*** ____________________