Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

New Patient

Please answer every question.

STAFF: Handwritten responses must be entered **MANUALLY**.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

HISTORY OF PRESENT ILLNESS

How did you arrive today?	wheelchair ◯	crutches ◯	cane ◯	walker ◯	no assistance ◯
Who is with you today?			self ◯	male ◯	female ◯
Is this a work-related injury?				yes ◯	no ◯
If "yes", has it been reported to your employer?				yes ◯	no ◯
If your pain is due to an accident, is legal action or an insurance settlement pending?				yes ◯	no ◯

If "yes", date of accident: _____

CHIEF COMPLAINT

Please indicate the most significant area of pain on this form and discuss the remaining issues with your physician.

Location of pain?	right side ◯	left side ◯	both sides ◯	midline ◯	
HEADACHE:	yes ◯	no ◯			
		If "yes":	all over ◯	back of head ◯	
			deep inside ◯	top of head ◯	
			forehead ◯	beneath eye(s) ◯	
			side of head ◯	behind eye(s) ◯	
NECK PAIN:	yes ◯	no ◯			
		If "yes":		front of neck ◯	
			entire neck ◯	back of neck ◯	
ABDOMINAL or PELVIC PAIN:	yes ◯	no ◯			
		If "yes":		above navel ◯	
			pelvis ◯	below navel ◯	
UPPER BACK PAIN:	yes ◯	no ◯			
		If "yes":		above the shoulder blades ◯	
				level with the shoulder blades ◯	
				below the level of the shoulder blades ◯	
				entire upper back ◯	
LOWER BACK PAIN:	yes ◯	no ◯			
		If "yes":		lumbar (lower back) ◯	
				sacral (tailbone area) ◯	
				flank (kidney area) ◯	
OTHER:	yes ◯	no ◯			

Area of pain: _____

Quality of current pain *(mark all that apply)*:

	crushing ◯	pressure ◯	sore ◯
aching ◯	gnawing ◯	sharp ◯	stabbing ◯
burning ◯	pins and needles sensation ◯	shock-like ◯	throbbing ◯

Pain score on scale from 0-10: *(0 being no pain to 10 being most severe pain imaginable)*

	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯		
No Pain ☺	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	☹	**Most Severe Pain Imaginable**

Timing of pain:

Are you experiencing the problem now?			yes ◯	no ◯
How long have you had the pain?	days ◯	weeks ◯	months ◯	years ◯

HISTORY OF PRESENT ILLNESS (continued)

Is there referred (RADIATING) pain, numbness, or tingling? *(If "yes", complete below)* yes ○ no ○

Please mark all RADIATING pain, numbness, or tingling you are experiencing *(Mark all that apply.)*

Radiating PAIN to:	Right	Left
Buttock	○	○
Groin	○	○
Hip	○	○
Leg	○	○
Foot	○	○
Shoulder	○	○
Arm	○	○
Hand	○	○
Finger(s)	○	○

Radiating NUMBNESS to:	Right	Left
Buttock	○	○
Groin	○	○
Hip	○	○
Leg	○	○
Foot	○	○
Shoulder	○	○
Arm	○	○
Hand	○	○
Finger(s)	○	○

Radiating TINGLING to:	Right	Left
Buttock	○	○
Groin	○	○
Hip	○	○
Leg	○	○
Foot	○	○
Shoulder	○	○
Arm	○	○
Hand	○	○
Finger(s)	○	○

FACTORS THAT AGGRAVATE THE PAIN *(mark all that apply)*

- alcohol ○
- food / beverages other than alcohol ○
- lying on / touching the affected area ○
- physical activity ○
- chewing ○
- coughing ○
- sneezing ○
- nasal congestion ○
- climbing stairs ○
- running / jogging ○
- walking ○
- sitting ○
- driving ○
- standing ○
- turning head ○
- twisting ○
- overhead lifting ○
- reaching up ○
- bending forward ○
- bending backward ○
- stress ○
- other *(please specify)*: ○

_____

_____

FACTORS THAT RELIEVE THE PAIN *(mark all that apply)*

- **NONE IDENTIFIED** ○
- applying cold ○
- applying heat ○
- lying down ○
- sitting down ○
- massaging the affected area ○
- stopping activity that causes problem ○
- walking / moving around ○
- avoiding bright light ○
- going into a dark room ○
- exercise ○
- avoiding emotional stress ○
- avoiding loud noises ○
- other *(please specify)*: ○

_____

PREVIOUS TREATMENTS

Please mark all previous treatments you have had in the last 12 months. Mark all that apply. If you had any of the following, please indicate the effect it had.

○ **NONE**				
Chiropractic Care	resolved ○	better ○	worse ○	no change ○
Injection Therapy	resolved ○	better ○	worse ○	no change ○
Massage Therapy	resolved ○	better ○	worse ○	no change ○
Physical Therapy	resolved ○	better ○	worse ○	no change ○
Home Exercise Program	resolved ○	better ○	worse ○	no change ○
Acupuncture	resolved ○	better ○	worse ○	no change ○
Medication(s) PRESCRIPTION		effective ○	non-effective ○	
Medication(s) OVER THE COUNTER		effective ○	non-effective ○	

○ **Other:** *(please specify)*

_____

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New Patient

Please answer every question.

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MEDICATIONS & ALLERGIES

Please check "yes" or "no" for each of the following.

	Yes	No
Are you taking any medication, including prescription, over the counter, or herbal?		
Are you allergic to any medication? *(If yes, information will be taken at the time of visit.)*		
Are you allergic to latex?		
Are you allergic to tape?		
Are you allergic to iodine?		
Are you allergic to contrast dye?		

SOCIAL HISTORY

Are you currently employed? yes ◯ no ◯

Occupation: _____

Height: _____ **Weight:** _____

If female, are you pregnant? no ◯ yes ◯ maybe ◯ **Due date:** _____

TOBACCO

What is your smoking status? current (every day) ◯ current (some days) ◯ previous ◯ never ◯

How many packs of cigarettes do you (or did you) smoke daily?

<½ ◯ ½ ◯ ¾ ◯ 1 ◯ 1 ½ ◯ 2 ◯ >2 ◯

If you smoke (or did smoke), how many years have you smoked?

(If you smoked intermittently, add the years that you smoked.)

Example: 21 is marked

10 ◯ 20 ● 1 ● 2 ◯

10 ◯ 20 ◯ 30 ◯ 40 ◯ 50 ◯ 60 ◯ 70 ◯ 80 ◯ 90 ◯

1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯

If you smoked previously, when did you stop smoking? (In months)

<2 ◯ 2-6 ◯ 6-12 ◯ 12-24 ◯ >24 ◯

ALCOHOL

Alcoholic drinks per day:

occasional ◯ 1 ◯ 2 ◯ 3 ◯ >3 ◯ NONE ◯

If you drink, what type(s) of alcohol? beer ◯ liquor ◯ wine ◯

DRUGS

Have you ever been addicted to or dependent on drugs or pain medication? yes ◯ no ◯

CAFFEINE

How would you describe your caffeine intake?

occasional ◯ 1 cup / day ◯ 2-3 cups / day ◯ 4 or more / day ◯ NONE ◯

EXERCISE

How would you describe your exercise level?

occasional ◯ regularly (1-2 times / week) ◯ regularly (3 or more times / week) ◯ NONE ◯

HOME LIVING SITUATION

How would you describe your home living situation? *(Mark all that apply.)*

alone ◯ spouse ◯ children ◯ mother ◯ father ◯ nursing facility ◯ assisted living ◯ other *(please specify)*: ◯ _____

FAMILY HISTORY

Please indicate if YOUR FAMILY has a history of the following. Mark all that apply.

◯ **FAMILY HISTORY UNKNOWN**

	Parent(s)	Sibling(s)
Bleeding Tendency	◯	◯
Blood Clots	◯	◯
Cancer	◯	◯
Depression	◯	◯
Diabetes	◯	◯
Heart Attack	◯	◯
Heart Disease	◯	◯
High Blood Pressure	◯	◯
Rheumatoid Arthritis	◯	◯
Osteoarthritis	◯	◯
Stroke	◯	◯
Migraines	◯	◯
NONE	◯	◯

SURGERIES

Please indicate if YOU have had any of the following surgeries.
Mark all that apply. If you have had no surgeries, mark "I HAVE HAD NO SURGERIES".

- ◯ **I HAVE HAD NO SURGERIES**
- ◯ Appendectomy
- ◯ Cardiac Bypass
- ◯ Cataracts
- ◯ Fracture repair of: _____
- ◯ Gallbladder
- ◯ Hernia
- Hip Replacement — right ◯ left ◯
- Knee Cartilage — right ◯ left ◯
- Knee Ligament — right ◯ left ◯
- Knee Replacement — right ◯ left ◯
- Shoulder — right ◯ left ◯
- Spinal Fusion — neck ◯ back ◯
- Spinal Decompression — neck ◯ back ◯
- ◯ Tonsillectomy
- ◯ Hysterectomy (Female only)

◯ Other: *(please specify)*_____

YOUR MEDICAL HISTORY

Please indicate if YOU have a history of the following.
Mark all that apply.

◯ Diabetes	◯ Pneumonia
◯ Blood Transfusion(s)	◯ Major Injury(ies)
◯ Sleep Apnea	◯ Cancer
◯ Chemotherapy / Radiation	◯ HIV / AIDS
◯ Hepatitis	◯ Glaucoma
◯ Chronic Migraines or Headaches	◯ Congestive Heart Failure
◯ High Blood Pressure	◯ Heart Attack
◯ Heart Disease	◯ Pacemaker
◯ Cardiac Stent	◯ Heart Valve Implant
◯ Implanted Defibrillator	◯ Emphysema
◯ Do you have a Cardiologist? →	Who: _____
◯ Asthma	◯ Tuberculosis
◯ COPD	◯ Fibromyalgia
◯ Breast Biopsy	◯ Chronic or Past GI Disorder(s)
◯ Mastectomy	◯ Dialysis
◯ Kidney Problem(s)	◯ Kidney Stone(s)
◯ Irritable Bowel Syndrome (IBS)	◯ Jaundice
◯ Kidney Failure	◯ Rheumatoid Arthritis
◯ Kidney Transplant	◯ Osteoarthritis
◯ Osteoporosis	◯ Gout
◯ Lupus / SLE	◯ Stroke
◯ Paralysis	◯ Seizure
◯ Epilepsy	◯ Head Injury
◯ Alzheimer's Disease	◯ Chronic or Past Neurologic Disease
◯ Anemia	◯ Phlebitis
◯ Blood Clots	◯ Sickle Cell Trait or Disease
◯ PVD	

◯ Other: *(please specify)*_____

Any complication with local anesthesia? yes ◯ no ◯
Any complication with general anesthesia? yes ◯ no ◯