

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?

☐ No ☐ Yes When?

Whom may we thank for referring you?

If so, whom?

Gender

☐ Male ☐ Female

Your Last Name

Your Social Security Number

Your First Name

Your Middle Name (or Initial)

Birth Date (MM/DD/YYYY)

Marital Status

☐ Single ☐ Married ☐ Divorced

☐ Widowed ☐ Separated

Address

City

State/Province

ZIP/Postal Code

Home Phone

Spouse's Name

Email Address

Cell Phone/Carrier

Child's Name and Age

Emergency Contact

Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

May we contact you at work?

☐ Yes ☐ No

Preferred method of contact?

☐ Home Phone ☐ Cell Phone

☐ Work Phone ☐ Email

Address

City

State/Province

ZIP/Postal Code

Work Phone

Insurance Carrier

Policy Number

Primary Care Provider's Name

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?

☐ Self ☐ Spouse ☐ Parent

First Name

Middle Name (or Initial)

Insured's Employer

Address

City

State/Province

ZIP/Postal Code

Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

1. The symptom(s) that have prompted me to seek care today include: _____

2. And are the result of (darken circle): ☐ An accident or injury
☐ Work ☐ Auto ☐ Other _____
☐ A worsening long-term problem
☐ An interest in: ☐ Wellness ☐ Other _____

3. Onset (When did you first notice your current symptoms?) _____
4. Intensity (How extreme are your current symptoms?)
0 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ 10
Absent Uncomfortable Agonizing
5. Duration and Timing (When did it start and how often do you feel it?)
☐ Constant ☐ Comes and goes. How Often? _____

6. Quality of symptoms (What does it feel like?)

☐ Numbness

☐ Tingling

☐ Stiffness

☐ Dull

☐ Aching

☐ Cramps

☐ Nagging

☐ Sharp

☐ Burning

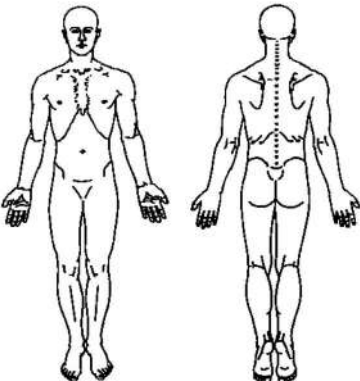
☐ Shooting

☐ Throbbing

☐ Stabbing

☐ Other _____

7. Location (Where does it hurt?)
Circle the area(s) on the illustration.
"O" for current condition
"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

What tends to worsen the problem? _____
What tends to lessen the problem? _____

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)
What tends to worsen the problem? _____
What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptoms?)

☐ Prescription medication ☐ Surgery ☐ Ice

☐ Over-the-counter drugs ☐ Acupuncture ☐ Heat

☐ Homeopathic remedies ☐ Chiropractic ☐ Other _____

☐ Physical therapy ☐ Massage _____

11. What else should New Life Chiropractic know about your current condition? _____

12. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

13. Review of Systems
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've Had or currently Have and initial to the right.

a. Musculoskeletal						
Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>
<input type="radio"/> Osteoporosis	<input type="radio"/> Arthritis	<input type="radio"/> Scoliosis	<input type="radio"/> Neck pain	<input type="radio"/> Back problems	<input type="radio"/> Hip disorders	Initials _____
<input type="radio"/> Knee injuries	<input type="radio"/> Foot/ankle pain	<input type="radio"/> Shoulder problems	<input type="radio"/> Elbow/wrist pain	<input type="radio"/> TMJ issues	<input type="radio"/> Poor posture	
b. Neurological						
Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>
<input type="radio"/> Anxiety	<input type="radio"/> Depression	<input type="radio"/> Headache	<input type="radio"/> Dizziness	<input type="radio"/> Pins and needles	<input type="radio"/> Numbness	Initials _____
c. Cardiovascular						
Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>
<input type="radio"/> High blood pressure	<input type="radio"/> Low blood pressure	<input type="radio"/> High cholesterol	<input type="radio"/> Poor circulation	<input type="radio"/> Angina	<input type="radio"/> Excessive bruising	Initials _____
d. Respiratory						
Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>
<input type="radio"/> Asthma	<input type="radio"/> Apnea	<input type="radio"/> Emphysema	<input type="radio"/> Hay fever	<input type="radio"/> Shortness of breath	<input type="radio"/> Pneumonia	Initials _____
e. Digestive						
Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>
<input type="radio"/> Anorexia/bulimia	<input type="radio"/> Ulcer	<input type="radio"/> Food sensitivities	<input type="radio"/> Heartburn	<input type="radio"/> Constipation	<input type="radio"/> Diarrhea	Initials _____
f. Sensory						
Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>
<input type="radio"/> Blurred vision	<input type="radio"/> Ringing in ears	<input type="radio"/> Hearing loss	<input type="radio"/> Chronic ear infection	<input type="radio"/> Loss of smell	<input type="radio"/> Loss of taste	Initials _____
g. Integumentary						
Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>
<input type="radio"/> Skin cancer	<input type="radio"/> Psoriasis	<input type="radio"/> Eczema	<input type="radio"/> Acne	<input type="radio"/> Hair loss	<input type="radio"/> Rash	Initials _____

Patient name _____

Consultation Notes

Doctor's Initials _____

New Life Chiropractic

h. Endocrine

Had <input type="radio"/> Have <input type="radio"/> Thyroid issues	Had <input type="radio"/> Have <input type="radio"/> Immune disorders	Had <input type="radio"/> Have <input type="radio"/> Hypoglycemia	Had <input type="radio"/> Have <input type="radio"/> Frequent infection	Had <input type="radio"/> Have <input type="radio"/> Swollen glands	Had <input type="radio"/> Have <input type="radio"/> Low energy	NONE <input type="radio"/>
						Initials _____
i. Genitourinary						
Had <input type="radio"/> Have <input type="radio"/> Kidney stones	Had <input type="radio"/> Have <input type="radio"/> Infertility	Had <input type="radio"/> Have <input type="radio"/> Bedwetting	Had <input type="radio"/> Have <input type="radio"/> Prostate issues	Had <input type="radio"/> Have <input type="radio"/> Erectile dysfunction	Had <input type="radio"/> Have <input type="radio"/> PMS symptoms	NONE <input type="radio"/>
						Initials _____
j. Constitutional						
Had <input type="radio"/> Have <input type="radio"/> Fainting	Had <input type="radio"/> Have <input type="radio"/> Low libido	Had <input type="radio"/> Have <input type="radio"/> Poor appetite	Had <input type="radio"/> Have <input type="radio"/> Fatigue	Had <input type="radio"/> Have <input type="radio"/> Sudden weight gain/loss (circle one)	Had <input type="radio"/> Have <input type="radio"/> Weakness	NONE <input type="radio"/>
						Initials _____

Initials _____

☐ All other systems negative

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Typhoid fever
<input type="checkbox"/>	<input type="checkbox"/>	Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer _____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer			Other: _____
<input type="checkbox"/>	<input type="checkbox"/>	Chicken pox			_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes			_____
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy			_____
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma			_____
<input type="checkbox"/>	<input type="checkbox"/>	Goiter			_____
<input type="checkbox"/>	<input type="checkbox"/>	Gout			_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease			_____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis			
<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive			
<input type="checkbox"/>	<input type="checkbox"/>	Malaria			
<input type="checkbox"/>	<input type="checkbox"/>	Measles			
<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis			
<input type="checkbox"/>	<input type="checkbox"/>	Mumps			
<input type="checkbox"/>	<input type="checkbox"/>	Polio			
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever			
<input type="checkbox"/>	<input type="checkbox"/>	Scarlet fever			
<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease			
<input type="checkbox"/>	<input type="checkbox"/>	Stroke			

17. Injuries

Have you ever...

<input type="checkbox"/>	Had a fractured or broken bone
<input type="checkbox"/>	Had a spine or nerve disorder
<input type="checkbox"/>	Been knocked unconscious
<input type="checkbox"/>	Been injured in an accident

15. Operations

Surgical interventions, which may or may not have included hospitalization.

<input type="checkbox"/>	Appendix removal
<input type="checkbox"/>	Bypass surgery
<input type="checkbox"/>	Cancer
<input type="checkbox"/>	Cosmetic surgery
<input type="checkbox"/>	Elective surgery: _____
<input type="checkbox"/>	_____
<input type="checkbox"/>	Eye surgery
<input type="checkbox"/>	Hysterectomy
<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	Spine _____
<input type="checkbox"/>	_____
<input type="checkbox"/>	Tonsillectomy
<input type="checkbox"/>	Vasectomy
<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	_____
<input type="checkbox"/>	_____
<input type="checkbox"/>	_____

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
<input type="checkbox"/>	<input type="checkbox"/>	Acupuncture
<input type="checkbox"/>	<input type="checkbox"/>	Antibiotics
<input type="checkbox"/>	<input type="checkbox"/>	Birth control pills
<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusions
<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy
<input type="checkbox"/>	<input type="checkbox"/>	Chiropractic care
<input type="checkbox"/>	<input type="checkbox"/>	Dialysis
<input type="checkbox"/>	<input type="checkbox"/>	Herbs
<input type="checkbox"/>	<input type="checkbox"/>	Homeopathy
<input type="checkbox"/>	<input type="checkbox"/>	Hormone replacement
<input type="checkbox"/>	<input type="checkbox"/>	Inhaler
<input type="checkbox"/>	<input type="checkbox"/>	Massage therapy
<input type="checkbox"/>	<input type="checkbox"/>	Physical therapy
<input type="checkbox"/>	<input type="checkbox"/>	Nutritional supplements:

List:

☐

☐

Medications (prescription and over-the-counter):

Some health issues are hereditary. Tell New Life Chiropractic about the health of your immediate family members.

FAMILY	Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
			Good	Poor			Natural	Illness
	Mother	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>
	Father	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>
	Sister 1	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>
	Sister 2	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>
	Brother 1	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>
	Brother 2	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>

19. Are there any other hereditary health issues that you know about?

Tell New Life Chiropractic about your health habits and stress levels.

SOCIAL		PERSONAL		ENVIRONMENTAL	
Alcohol use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Prayer or meditation?	<input type="radio"/> Yes <input type="radio"/> No	
Coffee use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Job pressure/stress?	<input type="radio"/> Yes <input type="radio"/> No	
Tobacco use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Financial peace?	<input type="radio"/> Yes <input type="radio"/> No	
Exercising	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Vaccinated?	<input type="radio"/> Yes <input type="radio"/> No	
Pain relievers	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Mercury fillings?	<input type="radio"/> Yes <input type="radio"/> No	
Soft drinks	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Recreational drugs?	<input type="radio"/> Yes <input type="radio"/> No	
Water intake	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____			
Hobbies:					

Consultation Notes

New Life Chiropractic

21. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

22. What is the major stressor in your life? _____ 23. How much sleep do you average per night? _____ Hours

24. What is the type and approximate age of your mattress and pillow? _____ 25. What is your preferred sleeping position? _____

26. Describe your typical eating habits: ☐ Skip breakfast ☐ Two meals a day ☐ Three meals a day ☐ Snacking between meals

27. What would be the most significant thing that you could do to improve your health? _____

28. In addition to the main reason for your visit today, what additional health goals do you have? _____

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____

I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials _____

I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials _____

I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____

Initials _____

I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials _____

I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials _____

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor child, print child's full name: _____

Signature _____

Date (MM/DD/YYYY) _____

Patient name _____

Consultation Notes

Doctor's Initials _____

New Life Chiropractic