New Patient Questionnaire

CONDFIDENTIAL PATIENT INFORMATION

Last Name _____

First _____ M.I._____

Address _____

City_____ State _____ Zip _____

Sex ☐ M ☐ F Date of Birth _____ Age_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse's Name:_____

No. of Children _____

School/Employer_____

Occupation_____ Years on Job_____

Whom may we thank for referring you?

_____

PHONE NUMBERS

Home _____Cell _____

Email Address _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Home _____Cell _____

Relationship_____

YOUR HEALTH GOALS

Please share your top three health goals:

1._____

_____

2._____

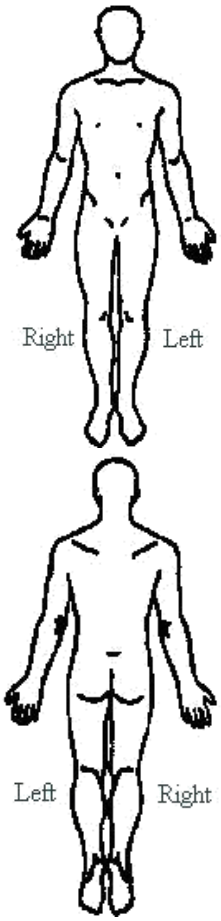
_____

3._____

_____

CURRENT HEALTH HISTORY

Please mark an X on the pictures to the right where you have pain, numbness, or tingling:



What is your major symptom/problem: _____

When did your symptoms first appear? _____

Are your symptoms getting ☐ better ☐ worse ☐ staying about the same?

Have you ever had this problem before? ☐ Yes ☐ No If so, when:_____

How often do you have this pain/symptom?_____

Is the pain/symptom ☐ constant? Or does it ☐ come and go?

Rate the severity of your pain on a scale from 1 to 10_____
(1- 3 mild pain, 4-6 moderate pain, 7-10 severe pain with 10 being the worst pain *imaginable*.)

How does it feel? ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numb ☐ Aching
☐ Shooting ☐ Burning ☐ Tingling ☐ Cramping ☐ Stiff ☐ Other _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation?

Activities that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking
☐ Bending ☐ Lying Down ☐ Other_____

What treatments have you received for this condition?
☐ Chiropractic ☐ Physical Therapy ☐ Massage ☐ Ice/Heat ☐ Surgery
☐ Stretching/Exercises ☐ Medications ☐ Other _____

List other doctors who have treated you for this condition:_____

_____

TRAUMAS: Physical Injury History

Notable childhood injuries? ☐ Yes ☐ No If yes, please explain: _____

Youth or college sports? ☐ Yes ☐ No If yes, list major injuries: _____

Have you ever been in an auto accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

If yes, please describe: _____

Exercise Frequency? ☐ None ☐ 1-3x per week ☐ 4-6x per week ☐ Daily

What types of exercise? _____

Do you commute to work? ☐ Yes ☐ No If yes, how many minutes per day?_____

How many hours per day do you typically spend sitting at a desk or on a computer, tablet or phone? _____

How do you normally sleep? ☐ Back ☐ Side ☐ Stomach

Do you wake up: ☐ Refreshed and ready ☐ Stiff and tired

Age of mattress: _____ ☐ Comfortable ☐ Uncomfortable

Are you wearing: ☐ Heal lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports ?

Please describe any other injuries below:

Falls _____

Head Injuries _____

Broken Bones _____

Surgeries _____

TOXINS: Chemical & Environmental Exposure

Please rate your CONSUMPTION of each (please circle):

	None		*Moderate*		*High*		*None*		*Moderate*		*High*
Alcohol	1	2	3	4	5	Processed Foods	1	2	3	4	5
Water	1	2	3	4	5	Artificial Sweeteners	1	2	3	4	5
Sugar	1	2	3	4	5	Sugary Drinks	1	2	3	4	5
Dairy	1	2	3	4	5	Cigarettes	1	2	3	4	5
Gluten	1	2	3	4	5	Recreational Drugs	1	2	3	4	5

MEDICATIONS (include OTC, Rx and recreational)

_____

_____

_____

_____

Do you have an allergy to any drug? _____

VITAMINS/HERBS/MINERALS

_____

_____

_____

_____

_____

THOUGHTS: Emotional Stresses & Challenges

Please rate your STRESS for each (please circle):

	None		*Moderate*		*High*		*None*		*Moderate*		*High*
Home	1	2	3	4	5	Money	1	2	3	4	5
Work	1	2	3	4	5	Health	1	2	3	4	5
Life	1	2	3	4	5	Family	1	2	3	4	5

Have you ever:	YES	NO	
Had any mental/emotional disorders?	☐	☐	Describe briefly: _____
Have others in your family had such disorders?	☐	☐	Describe briefly: _____

Patient Signature: _____ Date: _____