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New Practice Member Medical History

Name____Age & DOB:_____-_____/____/_______SSN:__________

Address_______________________________________City________________State_________Zip___________

Phone (Cell)____________________________________ (Home)____

Email Address____Occupation________________________________

Employer's Name____Single / Married / Divorced / Widowed

Spouse's Name___________________________________Number of Children________________________________

Names, Ages, & Gender____

Who may we thank for referring you?____

List The Health Concerns that Brought You Into This Office

	Health Concern: Please list in order of severity	When did this problem start?	Have you had the problem before? If so, when?	Did the problem begin with an injury?	Are symptoms constant (C) or Intermittent (I)?
Chief Complaint:	____________	__________	____________	____________	____________
Second:	____________	__________	____________	____________	____________
Third:	____________	__________	____________	____________	____________
Fourth:	____________	__________	____________	____________	____________

Have you ever seen other doctors for these conditions? Yes No

If Yes: Chiropractor Medical Doctor Other____

Who?_______________________________When?______________________ Results?____________________________

>>>>>Below: Please mark **"P"** For In The **Past** OR Mark **"C"** for **Currently** Have:<<<<<

__Headaches
__Migraines
__Jaw/TMJ Pain
__Neck Pain
__Shoulder Pain
__Arm Pain
__Upper Back Pain
__Mid Back Pain
__Lower Back Pain
__Hip/Leg Pain
__Knee Pain
__Foot Pain

__Ear Infections
__Hearing Loss
__Ringing in the Ears
__Dizziness
__Loss of Energy
__Nervousness
__Double/Blurry Vision
__Anxiety
__ADD/ADHD
__Loss of Balance
__Depression
__Allergies

__Sinus Issues
__Frequent Colds
__Thyroid Issues
__Asthma
__Chest Pain
__Heart Problems
__Nausea
__Ulcers
__Digestive Issues
__Diarrhea
__Constipation
__Bed Wetting

__Kidney Problems
__Bladder Problems
__Menstrual Problems
__Prostate Problems
__Infertility
__Fibromyalgia
__Epilepsy/Convulsions
__Tremors
__Disc Problems
__Scoliosis
__Poor Posture
__Skin Problems

__Sexual Dysfunction
__Sleep Problems
__Tight/Sore Muscles
__Sports Injury
__Sciatica
__Arthritis/Joint Pain
__GERD/Gastric Reflux
__Numb/Tingling in Arms
__Numb/Tingling in Legs/Feet
__Stomach Problems
__High/Low Blood Pressure
__Difficulty Breathing

__Pregnant __Stroke __Cancer __Heart Attack __Spinal Surgery

__Diabetes __Arthritis __Seizures Other:_______________________________________

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List all surgical operations & years:____

List any other injuries to your spine, minor or major, that the doctor should know about:

____

List all over the counter & prescription medications you are on, & the reason for each: (May use back of this page)

____

Have you ever been in an auto accident? List all:____

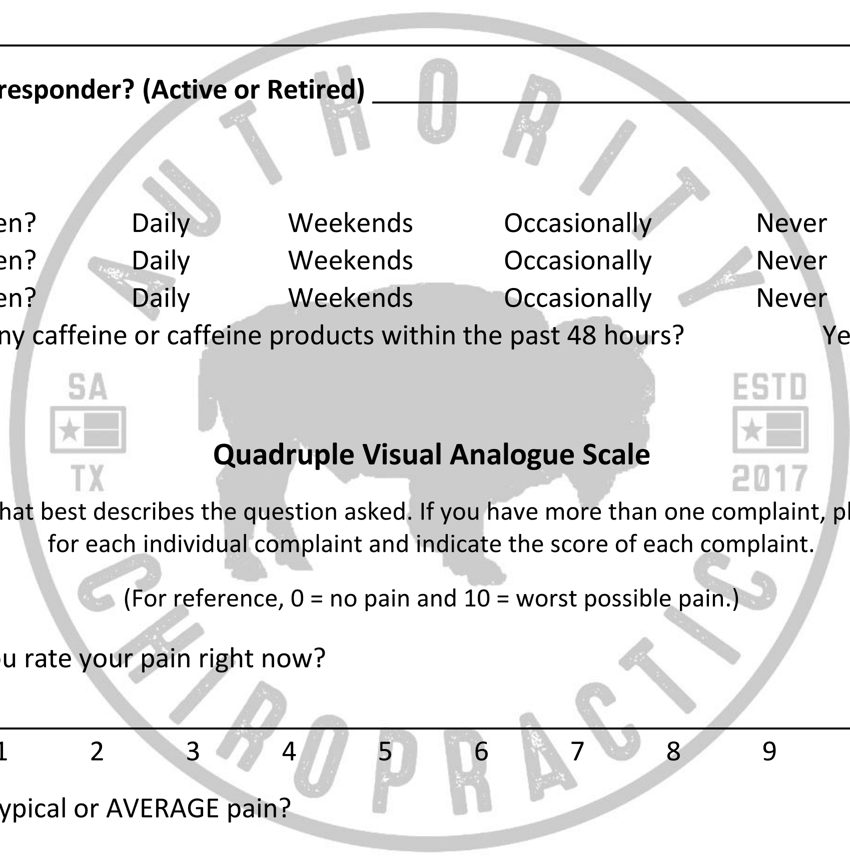
Do you have an open auto accident claim? Yes No

Have you ever been knocked unconscious? Yes No Fractured a Bone? Yes No

If yes to either of the above, please describe: ____

Other trauma: ____

Are you military or first responder? (Active or Retired) ____



Social History

1. Smoking:	How often?	Daily	Weekends	Occasionally	Never
2. Alcohol:	How often?	Daily	Weekends	Occasionally	Never
3. Exercise:	How often?	Daily	Weekends	Occasionally	Never

4. Have you consumed any caffeine or caffeine products within the past 48 hours? Yes No

Quadruple Visual Analogue Scale

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

(For reference, 0 = no pain and 10 = worst possible pain.)

1. How would you rate your pain right now?

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its BEST? (How close to 0 does your pain get at its best?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its best? ________%

4. What is your pain level at its WORST (How close to 10 does your pain get at its worst?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? _______%

Activities of Life

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITY	EFFECT			
Carrying Groceries	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Sit to Stand	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Climbing Stairs	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Pet Care	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Driving	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Extended Computer Use	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Household Chores	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Lifting Children	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Dressing	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Washing/Bathing	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Sexual Activities	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Sleep	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Static Sitting	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Static Standing	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Walking	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Yard Work	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Concentration (Reading)	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Other:_______________	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Other:_______________	No Effect	Painful (can do)	Painful (limits)	Unable to Perform

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How has your health affected your life in a negative way?

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____

____

____

If your body was functioning and adapting better, what are 2 things you would be able to do?

____

____

____

Family Health History

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
Headaches					
Neck Pain					
Jaw/TMJ Pain					
Shoulder Pain					
Back Pain					
Hip/Leg Pain					
Arthritis/Joint Pain					
Ear Infections					
Hearing Loss					
Dizziness					
Loss of Energy					
Nervousness					
Blurred/Double Vision					
Anxiety					
ADD/ADHD					
Depression					
Allergies					
Sinus Issues					
Thyroid Problems					
Asthma					
Breathing Problems					
Heart Problems					
High/Low Blood Pressure					
Stomach Problems					
Bed Wetting					
Infertility					
Sciatica					
Fibromyalgia					
Poor Posture					
Sleep Problems					
Stroke					
Cancer					
Heart Disease					
Diabetes					
Arthritis					
Alzheimer’s					

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