ABELS CHIROPRACTIC CENTRE
NEW PATIENT INFORMATION

Date _____ SS# _____ DOB _____ Case No. _____

Name _____

Address _____

City _____ State _____ Zip _____

Home # _____ Cell # _____ Work # _____

Present Employment _____

Single _____ Divorced _____ Widowed _____ Married _____

Spouse's Name _____

Ins. Carrier_____ Policy#_____Group#_____

Emergency Contact _____ Phone # _____

Address _____

Chief Complaint _____ When did this begin? _____

How did this begin? _____

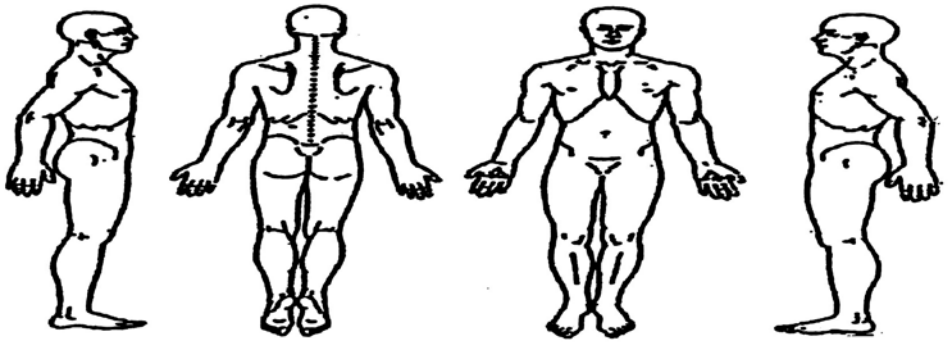
Have you been treated for this before? Yes_____ No_____ If so, When?_____

By? _____ Do you have access to recent x-rays? Yes_____ No_____

Who referred you to our office? _____

1. Is today's problem caused by: Auto Accident? _____ Work Related Accident? _____

2. Indicate on the drawings below where you have pain/symptoms:



3. How often do you experience your symptoms?

Constantly (76-100% of the time)_____ Occasionally (26-50% of the time) _____
Frequently (51-75% of the time) _____ Intermittently (1-25% of the time) _____

4. How would you describe the type of pain?

□ Sharp	□ Numb
□ Dull	□ Tingly
□ Diffuse	□ Sharp with motion
□ Achy	□ Shooting with motion
□ Burning	□ Stabbing with motion
□ Shooting	□ Electric like with motion
□ Stiff	□ Other:_____

5. How are your symptoms changing with time?
Getting Worse _____ Staying the Same _____ Getting Better _____

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?
Not at all _____ A little bit _____ Moderately _____ Quite a bit _____ Extremely _____

8. How much has the problem interfered with your social activities?
Not at all _____ A little bit _____ Moderately _____ Quite a bit _____ Extremely _____

9. Do you consider this problem to be severe?
Yes _____ Yes, at times _____ No _____

10. What aggravates your problem?

_____

11. What concerns you the most about your problem; what does it prevent you from doing?

_____

12. What is your: Height _____ Weight _____

13. How would you rate your overall Health?
Excellent _____ Very Good _____ Good _____ Fair _____ Poor _____

14. What type of exercise do you do?
Strenuous _____ Moderate _____ Light _____ None _____

15.Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus □ Heart Problems □ Cancer □ ALS

16. List all prescription medications you are currently taking:

_____

17. List all of the over-the-counter medications you are currently taking:

_____

18. List all surgical procedures you have had:

_____

19. What activities do you do at work?

□ Sit:	□ Most of the day	□ Half the day	□ A little of the day
□ Stand:	□ Most of the day	□ Half the day	□ A little of the day
□ Computer work:	□ Most of the day	□ Half the day	□ A little of the day
□ On the phone:	□ Most of the day	□ Half of the day	□ A little of the day

Name _____ Case No. _____

20. What activities do you do outside of work?_____
Name

21. Have you ever been hospitalized? No _____ Yes _____
If yes; why? _____

22. Have you had significant past trauma? No _____ Yes _____

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23. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Low Back Pain	□	□	Angina	□	□	Drug/Alcohol Dependent
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders	□	□	Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	Dermatitis/Eczema/Rash
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Abnormal Weight Gain/Loss			
□	□	Ankle/Foot Pain	□	□	Loss of Appetite	**For Females Only:**		
□	□	Jaw Pain	□	□	Abdominal Pain	□	□	Birth Control Pills
□	□	Joint Pain/Stiffness	□	□	Ulcer	□	□	Hormonal replacement
□	□	Arthritis	□	□	Hepatitis	□	□	Pregnancy
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder			
□	□	Cancer	□	□	General Fatigue	□	□	Other_____
□	□	Tumor	□	□	Muscular In coordination			
□	□	Asthma	□	□	Visual Disturbances			
□	□	Chronic Sinusitis	□	□	Dizziness			

24. Anything else pertinent to your visit today? _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate chiropractic care, any fees for professional services rendered me will be immediately due and payable. I hereby authorize the Doctor to treat my condition as he deems appropriate through use of chiropractic adjustments throughout my spine. It is understood and agreed the amount paid the Doctor, for X-rays, is for the examination only and the X-ray negatives will remain property of this office, being on file where they may be seen at any time while a patient of the office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient's Signature_____ Date _____

Guardian or Spouse's Signature _____ Date _____