



New Patient Information

Name _____ Date _____
 Address _____
 City _____ Prov. _____ P. Code _____
 Home Phone _____ Work Phone _____
 E-mail Address _____
 Date of Birth _____ Age _____
 Occupation _____ Employer _____
 Spouse/Partner Name (if applicable) _____
 Number of Children & Ages (if applicable) _____
 Have you ever received chiropractic care? Yes No
 Who referred you to our clinic? _____
 Emergency Contact: Name _____ Phone # _____

About Your Health

Yes	No		Patient Comments	Doctor Comments
<input type="checkbox"/>	<input type="checkbox"/>	Was your own delivery difficult?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Childhood sicknesses?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Childhood accidents?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you taught proper body movement and care?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you drink any alcohol?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diet (do you eat healthy foods?)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you exercise regularly?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have you been in accidents?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have you had surgery? (Describe)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Medications (prescriptive or over the counter?) (Describe)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Eye problems?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hearing problems?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have occupational stress?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Physical stress?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mental stress?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hobbies/Sports injuries?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other traumas or problems	_____	_____

Sleeping Posture: Side Stomach Back
 Have you ever been in an accident? Yes No
 If yes, work auto other

Present Symptoms

Major Complaint (Please be specific) _____

Secondary complaint (Please be specific) _____

When did condition/pain start? _____

What caused your complaint? _____

Pains are Sharp Dull Constant Intermittent

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is condition worse during certain times of the day? AM PM

Is this condition interfering with work? _____

Is this condition interfering with your sleep? _____

Is this condition getting progressively (please circle one): **worse** **better** **same**

Other doctors seen for this condition, and when? _____

Any home remedies? _____

Other symptoms (check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Loss of Smell |
| <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Tension | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Low Back Stiffness | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Pain/Numbness in
Legs/Feet | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Pain/Numbness in
Arms/Hands | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Fever | <input type="checkbox"/> Buzzing in Ears |

Is there a family history of the following (check all that apply):

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

About Your Care

Chiropractic provides three types of care. The first is *Initial Intensive Care*, which corrects the most recent Spinal and Neurological injury. This care reduces or eliminates the symptoms.

Then begins *Reconstructive Care*, which corrects the chronic damage that occurred when there were few symptoms.

Finally, Chiropractic offers a genuine approach to *Wellness Care*.

All of these options will be explained at your report of findings. Then you will be able to begin a course of care that fits your health and goals.

Patient / Guardian Signature

____/____/____
Day Month Year