New Patient Application and Case History (N & C)

Name _____ Age _____ Sex: M F DOB _____ Today's Date _____

Address _____ City_____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

e-mail: _____ How Did You Hear About Us? _____

Who is responsible for this bill? _____

This information is a vital part of determining **if we can accept you as a patient** into our care programs. Please complete all information to the best of your ability. **DO NOT LEAVE ANY BLANKS**. **YOU MUST BRING THESE FORMS TO YOUR CONSULTATION.**

Present Health Issues or Complaints What is/are your Main Problem(s): _____?

Please list **ALL Other Current Health Conditions** (Please list all Diagnoses)

1.
2.
3.
4.
5.

Medications
(List ALL prescription, over-the-counter, botanicals, homeopathic, vitamins and supplements)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Medical and Social History

List ALL Surgeries/Hospitalizations Date List ALL Work/Sports Injury/Auto/or Other Accidents Date

_____ _____

_____ _____

_____ _____

List ANY Other Important Past/Recent Illnesses Date Any past/present research study participation? Y or N Date

_____ _____

_____ _____

Do you use a CPAP Machine? Y or N

Please list other doctors you have seen for your present condition. _____ ~ None

Dr. Name _____ Dr. Name _____

Has the treatment helped? ~ Yes ~ No ~ Don't Know

Previous chiropractic care? ~ No ~ Yes: Dr. _____ Address _____

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SYMPTOMS ARE THINGS THAT ARE DIFFERENT ABOUT YOUR BODY. PLEASE ANSWER REGARDING ALL CHANGES THAT YOU HAVE. DO NOT FORGET THE ONES THAT YOU HAVE BECOME ACCUSTOMED TO.

Tell us about symptoms that you may have (list all) and when did they start:

What relieves your symptoms or causes them to return:

Do your symptoms occur at a specific time, place, Y or N

Do your symptoms include pain? Y or N What is the type of pain. (sharp, dull, stabbing,, etc.):

How long does pain last each episode? Does the pain radiate: Y or N If yes, to where? _____

Do you follow a regular exercise routine? Y or N # _____ of days per week?

Have you had any past or recent weight loss? Y or N Please explain.

Tell us about you and your family.

Employer _____ ☐Retired Occupation (Current or Past) _____ Length of Employment _____

SSN _____-_____-_____ Height _____ Weight: _____

Marital Status: S / M / W / Sep / D Spouse/Partner Name _____

No. of Children = _____, their ages: ___ ___ ___ ___ ___ ___ No. of Grandchildren = _____
No. of Great Grandchildren = _____

Family History of Diabetes, Cancer, Heart Disease, etc. (Please list for mother, father, siblings, spouse, and children)

_____ _____ _____ _____

_____ _____ _____ _____

Please list any other unusual/genetic Disease/s that you have –or- runs in your family. _____

Do you use:
Alcohol Y N ___ drinks/week Tobacco Y N ___ pack/day Caffeine Y N ___ cups/day Artificial Sweeteners Y N

Dink Soda Y N ___ drinks/week Source _____ Source _____

What are your goals for care?
☐ Symptom relief ☐ Prevent from recurring ☐ Holistic or Wellness Care ☐ Correct the problem

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Patient Name _____ **Date:** _____

Review of Systems: Past and Current

(Have you ever had the following (circle "P" for past and "C" for current - Leave blank if you do not or have not experienced)

CONSTITUTIONAL
PC Fatigue
PC Recent weight change
PC Fever
PC Skin becoming dryer

EYES
PC Eye disease or injury
PC Eye medication
PC Glasses/contacts
PC Blurred/double vision

EAR/NOSE/MOUTH/THROAT
PC Mouth sores / Bleeding gums
PC Nose bleeds
PC Sinus problems/rhinitis
PC Swollen glands in neck
PC Hearing loss or ringing
PC Earaches or drainage
PC Sore throat or voice change
PC Bad breath / bad taste

CARDIOVASCULAR
PC High or Low Blood Pressure
PC Shortness of breath walking
PC Heart disease
PC Chest pain or angina pectoris
PC Palpitations
PC Mitral Valve Prolapse
PC Feet or ankle swelling
PC Shortness of breath
PC Stents or Bypass

GENITOURINARY
PC Frequent urination
PC Burning or painful urination
PC Blood in urine
PC Change in force or strain urinating
PC Kidney stones
PC Kidney Disease
PC Bladder Infections
PC Sexual difficulty
PC Male: testicle pain
PC Female: pain/irregular periods
PC Female: pregnant

GASTROINTESTINAL
PC Hemorrhoids
PC Painful bm / constipation
PC Rectal bleeding/blood in stool
PC Nausea or Vomiting
PC Abdominal pain
PC Frequent diarrhea
PC Loss of appetite
PC Change in bowel movement
PC Heartburn/ GERD

RESPIRATORY
PC Chronic or frequent cough
PC Pneumonia / Bronchitis
PC Shortness of breath
PC Wheezing/Asthma
PC Sleep Apnea

ENDOCRINE
PC Glandular/ hormone problem
PC Excessive thirst or urination
PC Heat or cold intolerance
PC Change in hat or glove size
PC Diabetes
PC Thyroid Disease

PSYCHIATRIC
PC Insomnia
PC Memory loss or confusion
PC Nervousness
PC Depression

MUSCULOSKELETAL
PC Back pain
PC Joint pain
PC Joint stiffness and swelling
PC Muscle pain or cramps
PC Muscle or joint weakness
PC Difficulty walking
PC Neck Pain
PC Rheumatoid Arthritis
PC Gout

INTEGUMENT (skin, breast)
PC Change in skin color
PC Change in Hair or Nails
PC Rash or itching
PC Breast pain / discharge
PC Breast lump
PC Hives or Eczema

NEUROLOGY
PC Freq./ recurring headaches
PC Migraine headache
PC Convulsions or seizures
PC Numbness or tingling
PC Tremors
PC Paralysis
PC Head injury
PC Stroke or TIA's
PC Light headed or dizzy

HEMATOLOGY/ LYMPHATIC/ OTHER
PC Chicken pox
PC Blood/Plasma Transfusions
PC Slow to heal after cuts
PC Easy bleeding or bruising
PC Anemia
PC Varicose Veins
PC Past transfusion
PC Cancer
PC Enlarged glands
PC Ulcer
PC Hepatitis
PC Cold extremities
PC Infectious Mono
PC AIDS or HIV+
PC Venereal Disease
PC Others _____

ALLERGIES / OTHER (drugs, food, or environmental)

_____ _____

_____ _____

RECENT TESTS (lab work, x-rays, CT, MRI)

_____ _____

_____ _____

OTHER PROVIDERS (NAME AND PHONE #)

(PCP)_____ _____

_____ _____

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