New Patient Questionnaire
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(PLEASE PRINT)

Name_____Address_____

City, State_____ Zip Code_____ Email _____

Home Phone _____ Cell Phone _____ Birth Date _____ Age _____ Sex: M F

__ Married __ Single__ Divorce __ Spouse's Name _____# of children_____

Occupation _____Employed By _____ Wk. phone # _____

In case of emergency contact: Name _____ Phone_____

How were you referred to our office? _____ Friend' Name _____

Have you ever been under Chiropractic care before? _____ When _____ Dr.'s Name _____

List your chief complaints in order of severity:

1. _____ Onset Date_____ Pain Scale : 1-10 _____ How Often_____

2. _____ Onset Date_____ Pain Scale : 1-10 _____ How Often_____

3. _____ Onset Date_____ Pain Scale : 1-10 _____ How Often_____

4. _____ Onset Date_____ Pain Scale : 1-10 _____ How Often_____

Name of your medical doctor: _____ May we discuss your chiropractic care with your doctor ?_____

Please list other doctors consulted for this condition:

Doctor's Name _____ phone # _____ Address _____

Doctor's Name _____ phone # _____ Address _____

Do you have health insurance? _____ Company _____ Policy # _____

IMPORTANT: PLEASE CHECK ALL SYMPTOMS, PRESENT OR PAST PROBLEMS:

__ Headaches __ Sinus __ Dizziness __ Concentration Loss __ Depression __ Difficulty Sleeping __ Loss of Energy
__ Blurred Vision/Loss __ Loss of Taste __Difficulty Swallowing __ Difficulty Breathing __ Shortness of Breath __ Chest pain
__Heart Palpitations __ Lung problems __ Heart Problems __ High/ Low Blood Pressure __ Stomach Pain __ Indigestion
__ Colon Problems __ Constipation __ Diarrhea __ Kidney Problems __ Poor Circulation __ Other _____

1. Hospital/Surgeries _____

2. Currently taking any Medication?_____

3. Does anyone in your family suffer from back problems? _____

4. Any Auto Accidents? _____

Patient Signature:_____Date:_____

CONTINUED (SEE BACK PLEASE)

New Patient Questionnaire

Name _____ **Date** _____

The rating scale below is designated to measure the degree to which several aspects of your life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing). in other words, we would like to know how much your health condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do. Or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR CURRENT TYPICAL LEVEL OF ACTIVITIES AS THEY ARE NOW. O means no disability at all, and a score of 10 means that all of the activities in which YOU would normally be involved have been totally disrupted by your health condition (pain and /or symptoms you may be experiencing).

0 1 2 3 4 5 6 7 8 9 10

Complete Able to function — Totally Unable to function

Upon entering

1. **FAMILY/HOME RESPONSABILITIES:** Activities related to the home or family including chores and duties performance around the house (yard work, doing dishes, errands, favors for other family members, driving children to school, etc.) _____

2. **RECREATIONS:** Hobbies, Sports, and other similar leisure time activities _____

3. **SOCIAL ACTIVITY:** Activities which involve participation with friends and acquaintances other Than family members, including parties, theater, concerts, dining out, and other social functions. _____

4. **OCCUPATION:** Activities that are a part of or directly related to one's job including nonpaying jobs as well, such as that of a homemaker or volunteer worker. _____

5. **SELF CARE:** Activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.) _____

6. **LIFE SUPPORT ACTIVITY:** Basic life supporting behaviors such as eating, sleeping, and breathing _____

MARK AREAS OF PAIN:

BURNING STABBING SHARP DULL CONSISTENT COMES & GOES TINGLING NUMBNESS