

NEW PATIENT INFORMATION

Please print when completing the following questions. Please answer all the questions. If you need help, please ask the front desk.

Today's Date _____

Name _____ Date of Birth _____ Social Security No. _____

Address _____ City _____ State _____ Zip _____

Cell Phone # _____ Cell Phone Carrier/Provider _____

Male Female

Home Phone # _____ E-mail _____

Married Single Divorced Widowed Number of children and ages _____

Spouse's Name _____ Date of Birth _____ Social Security No. _____

Your Employer _____ Spouse's Employer _____

Phone # _____ EXT. _____ Phone _____ EXT. _____

Occupation _____ Occupation _____

Address _____ Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

How were you referred to this office? _____

Who is your family physician? _____

Have you been treated by a chiropractor before? Yes No If yes, who and when? _____

List your present complaints and describe your symptoms: Date of this injury? _____

Have you seen other doctors for your present condition? Yes No

If yes, how did they treat it and how did you respond? _____

Is this a work related injury? Yes No

Did you report it to your employer? Yes No

Is this an accidental injury? Yes No

Auto Accident? Yes No

Have you seen an attorney? Yes No If yes, who _____ Phone Number _____

Please explain: _____

By signing below, I understand that all charges are payable at the time of the visit. I also understand that charges for x-rays are for analysis, and that they remain the property of Active Health & Wellness Center.

Patient Signature _____ Date _____

Guardian/Responsible Party's Signature _____ Date _____

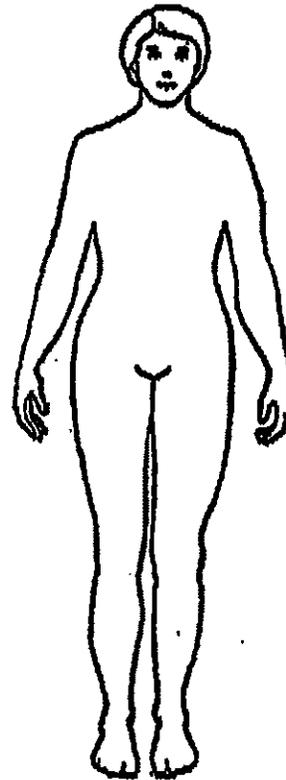
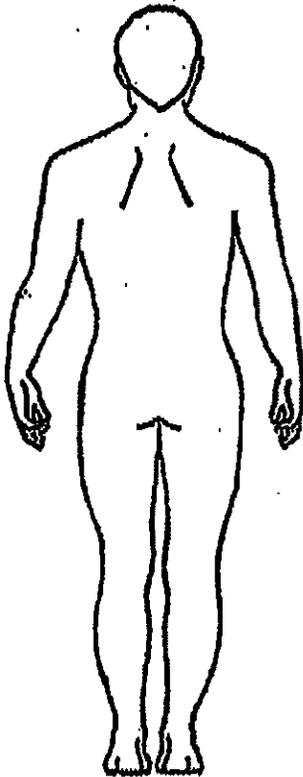
AREAS OF PAIN

Name _____

Date _____

Please indicate the appropriate location of pain and the symbol that best describes the discomfort you are presently experiencing.

Sharp and Stabbing = + + + +
 Dull and Achy = v v v v
 Pins and Needles = 0 0 0 0
 Numbness = / / / /



Patient Signature _____

Please check the appropriate square to describe your present limitations in function:

Activity	Normal	Mildly Limited	Moderately Limited	Severely Limited
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resting in Bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Name: _____ Account # _____ Date _____

EYES

- Double Vision
- Glasses
- Tearing
- Burning
- Eye Strain

EARS

- Deafness
- Discharge
- Ringing
- Excess Wax

SKIN

- Rashes
- Eruptions
- Discolorations

WEIGHT

- Gain
- Loss
- Hold the same

NOSE

- Sinusitis
- Bleeding
- Post Nasal Drip
- Obstruction

THROAT

- Soreness
- Hoarseness
- Difficulty Swallowing

HEAD

- Headaches
- Trauma
- Dizziness
- Fainting

CHEST

- Pain
- Heart Pounding
- Difficulty Breathing
- Cough up blood or sputum

MUSCULAR

- Numbness
- Joint Pain
- Varicosities
- Swelling of hands/feet

URINARY (URINATION)

- Abnormally Frequent
- Burning
- Pain
- Discolored with Pus/Blood

FEMALE (ONLY)

- Irregular Periods
- Regular Periods
- Duration of Periods
- Number of Pregnancies
- Complication during pregnancy
- Menopause

**STOMACH OR
INTESTINES**

- Poor Appetite
- Nausea
- Vomiting
- Belching
- Diarrhea
- Constipation
- Hemorrhoids
- Rectal Bleeding
- Irregular Stool
- Hernia
- Ulcers

HABITS

- Coffee
- Tea
- Milk
- Water
- Fruit Juices
- Exercise
- Alcohol
- Cigarettes
- Drugs (Pot Etc.)

FEMALE ONLY: Are you pregnant? _____ yes _____ no _____ Patient Please Initial Here

Please list any medications/prescription drug you are currently taking? Examples: Antibiotics, anti-inflammatories, muscle relaxers, pain meds, sleeping pills, blood pressure meds, diabetic meds, birth control pills, or list others below: _____

Please list any vitamins/supplements you are currently taking? _____

DIAGNOSTIC SURVEY

Have you ever been x-rayed before? _____ When/Where _____
 Area of Body? _____ How many times? _____

Have you ever had an MRI or CT scan? _____ When/Where _____
 Area of Body? _____ How many times? _____

Have you ever had any radiation treatments? _____ When/Where? _____
 Have you ever had any chemotherapy treatments? _____ When/Where? _____

Patient Name: _____ Account # _____ Date _____

HISTORY: INJURIES (AUTO, FRACTURES, ETC.) EXPLAIN _____

PUT AN "X" IN FRONT OF THE FOLLOWING ILLNESSES WHICH YOU HAVE HAD:

- | | | | |
|-----------------------------------------|---------------------------------------|-----------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Nervous Breakdown |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Gall Stones | <input type="checkbox"/> "Leaking" heart |
| <input type="checkbox"/> Small pox | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Hepatitis or Jaundice |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Goiter | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hives or Eczema |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Migraine | <input type="checkbox"/> Meningitis | <input type="checkbox"/> any bone or joint |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Fractures | <input type="checkbox"/> Heart disease | <input type="checkbox"/> High blood pressure |
| | <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other |

FAMILY HISTORY - PUT AN "X" IN FRONT OF THOSE WHICH APPLY:

	LIVING	DEAD	CANCER	TB	DIABETES	BLOOD DISEASE	ALLERGY	HEART	ARTHRITIS
FATHER	_____	_____	_____	_____	_____	_____	_____	_____	_____
MOTHER	_____	_____	_____	_____	_____	_____	_____	_____	_____
SISTERS	_____	_____	_____	_____	_____	_____	_____	_____	_____
BROTHERS	_____	_____	_____	_____	_____	_____	_____	_____	_____

PUT THE DATE IN FRONT OF THOSE OPERATIONS WHICH YOU HAVE HAD:

_____	Cholecystectomy (Gall Bladder Operation)	_____	Tonsillectomy
_____	Herniorrhaphy (Hernia Operation)	_____	Adenoidectomy
_____	Hemorrhoidectomy (Hemorrhoid Operation)	_____	Appendectomy
_____	Hysterectomy (Uterine Operation)	_____	Vaginal Repair
_____	Prostatectomy (Prostate Operation)	_____	Other Surgery

Patient Name: _____ Account # _____ Date _____