PRICEPERFORMANCE CHIROPRACTIC

New Patient Information

Name:_____ How did you hear about us?_____

Date of Birth: _____ Social Security #: _____-_____-_____ Gender: ____Male ____Female

Address: _____

City: _____State: _____ Zip: _____ Marital Status:_____

Home Phone: _____-_____-_____ Work Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Email Address: _____ Occupation/Company Name: _____

Work Address:_____ Work City:_____ Work Zip:_____

List any **Allergies:**

__Animals	__Dairy	__Mold	__Soap	__X-Ray Dye
__Aspirin	__Dust	__Penicillin	__Season Allergies	__Other:_____
__Bees	__Eggs	__Ragweed/Pollen	__Shellfish	_____
__Chocolate	__Latex	__Rubber	__Wheat	_____

List any **Surgeries**:

__Back	__Elbow	__Hip	__Neck	__Shoulder	__Other:_____
__Brain	__Foot	__Knee	__Neurological	__Wrist	_____

List **ALL Past Medical History** conditions:

__Ankle Pain	__Diabetes	__Hand Pain	__Knee Pain	__Parkinson's
__Arm Pain	__Dizziness	__Headaches	__Leg Pain	__Polio
__Arthritis	__Elbow Pain	__Hearing Problems	__Menstrual Problems	__Prostate Problems
__Asthma	__Epilepsy	__Hepatitis	__Mid-Back Pain	__Shoulder Pain
__Back Pain	__Eye/Vision Problems	__High Blood Pressure	__Minor Heart Problems	__Significant Weight Change
__Broken Bones	__Fainting	__Hip Pain	__Multiple Sclerosis	__Spinal Cord Injury
__Cancer	__Fatigue	__HIV	__Neck Pain	__Sprain/Strain
__Chest Pain	__Foot Pain	__Jaw Pain	__Neurological Problems	__Stroke/Heart Attack
__Depression	__Spinal Condition	__Joint Stiffness	__Pacemaker	__Other:_____

List type of **Medications** you are taking:

__Anxiety	__Pain Killers	__Birth Control	__Allergy	Other:_____
__Muscle Relaxers	__Insulin	__Cardiovascular	__Seizure	_____

List your **Family History**:

__Arthritis __Depression __High Blood Pressure __Parkinson's

__Asthma __Diabetes __Heart Problems __Polio

__Back Pain __Epilepsy __Multiple Sclerosis __Prostate Problems

__Cancer __Genetic Spinal Condition __Neurological Problems __Stroke/Heart Attack

Please list all family members who had/has any of the problems above: (Example: Grandmother-high blood pressure)

_____

_____

Have you had any auto or other accidents? ___No ___Yes

Describe:_____

Date of last physical examination:_____

Do you smoke? ___No ___Yes

Do you drink alcohol? ___No ___Yes - how many per day? _____

Do you drink caffeine? ___No ___Yes - how many per day? _____

Do you exercise? ___No ___Yes (what form & how often):_____

Goals for your care: Have you ever had chiropractic care before? ___No ___Yes

___ **Relief Care:** Symptomatic relief of pain or discomfort When?_____

___ **Corrective Care:** Correcting & relieving the cause of the problem as well as the symptoms.

___ **Comprehensive Care:** Bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic.

___ **I want the Doctor to select the type of care appropriate for my condition.**

What is your **major** complaint? _____ Date problem began?_____

How did this problem begin (falling, lifting, etc.)?_____

How is your condition changing? ___ getting better ___ getting worse ___not changing

Have you had this condition in the past? ___ Yes ___No

How often do you experience your symptoms?

___ Constantly (76%-100% of the day) ___ Frequently (51%-75% of the day)

___Occasionally (26%-50% of the day) ___Intermittently (0-25% of the day)

Describe the nature of your symptoms: ___ Sharp ___Dull ___Numb ___Burning ___Shooting ___Tingling ___Radiating Pain

___Stabbing ___Throbbing ___ Tightness Other:_____

Please rate your pain on a scale of 1 to 10 (0 = no pain and 10 = excruciating pain)

___0 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0 = no effect and 10 = no possible activity) ___0 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10

What activities aggravate your condition (working, exercise, etc)?_____

What makes your pain better (ice, heat, massage, etc)_____

What is your **second** complaint? _____ Date problem began?_____

How did this problem begin (falling, lifting, etc.)?_____

How is your condition changing? ___ getting better ___ getting worse ___not changing

Have you had this condition in the past? ___ Yes ___No

How often do you experience your symptoms?

___ Constantly (76%-100% of the day) ___ Frequently (51%-75% of the day)

___Occasionally (26%-50% of the day) ___Intermittently (0-25% of the day)

Describe the nature of your symptoms: ___ Sharp ___Dull ___Numb ___Burning ___Shooting ___Tingling ___Radiating Pain

___Stabbing ___Throbbing ___Tightness Other:_____

Please rate your pain on a scale of 1 to 10 (0 = no pain and 10 = excruciating pain)

___0 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0 = no effect and 10 = no possible activity) ___0 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10

What activities aggravate your condition (working, exercise, etc)?_____

What makes your pain better (ice, heat, massage, etc)_____

What is your **third** complaint? _____ Date problem began?_____

How did this problem begin (falling, lifting, etc.)?_____

How is your condition changing? ___ getting better ___ getting worse ___not changing

Have you had this condition in the past? ___ Yes ___No

How often do you experience your symptoms?

___Constantly (76%-100% of the day) ___Frequently (51%-75% of the day)

___Occasionally (26%-50% of the day) ___Intermittently (0-25% of the day)

Describe the nature of your symptoms: ___ Sharp ___Dull ___Numb ___Burning ___Shooting ___Tingling ___Radiating Pain

___Stabbing ___Throbbing ___Tightness Other:_____

Please rate your pain on a scale of 1 to 10 (0 = no pain and 10 = excruciating pain)

___0 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0 = no effect and 10 = no possible activity) ___0 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10

What activities aggravate your condition (working, exercise, etc)?_____

What makes your pain better (ice, heat, massage, etc)_____