Today's Date: ___________

New Patient Sheet

In order to carefully plan your treatment, your doctor requests the following information prior to the evaluation of your concern. Please complete this form and bring it with you prior to your appointment date.

Identifying Data

Patient Name ____
Last Name First Name Middle Initial

Birthdate ____________ Cell Phone __________________ E-mail ___________________

Occupation __________________________ ☐Student, School_______________________

Primary Care Physician ______________________ Clinic/Hospital ____________________

Whom may we thank for referring you? ____

IN CASE OF EMERGENCY, CONTACT

Name _______________________ Relationship_____________ Cell Phone_______________

Pain/Problem Area(s)

Please rank your concerns

1____
2____
3____
4____
5____

- Have you had this problem before, if so, how long?

Please describe ____

- Do you have numbness or tingling in extremities (paresthesia)?

Please describe ____

- Do you have weakness in extremities (paresis)?

Please describe ____

- What is your sleeping posture? ______________________________________

Headache ☐Yes ☐No

- How often? How severe? What aggravates?

____

Behavior Symptoms

What helps your pain?____

Any of these? Sit, Stand, Walk, Lay down, Stretch, Rest, Medicine, Heat, Ice, E-Stim

What aggravates your pain? ____

Any of these? Sit, Stand, Walk, Run, Lay down, Stretch, Bend over, Twisting, Rest, Eating, Going to the bathroom, Medication

Have you ever been treated with:

Chiropractic: ☐YES ☐NO For what? ______________________ Did it help? ☐YES ☐NO

Physical Therapy: ☐YES ☐NO For what? ______________________ Did it help? ☐YES ☐NO

Injections: ☐YES ☐NO For what? ______________________ Did it help? ☐YES ☐NO

Advanced Testing (Bring CD or images with you.)

Please check the box of imaging you have had and describe the findings

☐X-RAY ____

____

☐MRI ____

____

☐CT/Cat Scan ____

☐Nerve Conduction____

☐Ultrasound ____

☐Bone Scan ☐EMG ☐CT Myelogram

Medications

Please list medications you think are relevant

____

For Example Blood Pressure, cholesterol, Blood Clots, Diabetes

Medical History

Allergic to latex, adhesive, and/or lotion?____

*Other non-medication Allergies?*____

Please list all previous medical diagnosis of your current condition(s)

____

Briefly explain **all conditions you have been diagnosed with** and **past injuries** and that you have suffered. *For example: sprains/strains or tears, tendonitis, bone spurs, dental caries, etc. (Please be specific to site of injury)*

Previous Sports Injury? ____

Torn Ligament/meniscus:__________________________________

Broken Bone(s): ____

Spinal Hardware: ____
Other: ____
Do you have any type of **infection** at this time? ☐YES ☐NO
Surgery

____

Athletic History

Gym Membership? ☐Yes ☐No
Where?______________________________________
How do you exercise? (Check all that apply)

☐Running	☐Weightlifting	☐Body Weight Exercises
☐Walking	☐Body Building	☐Pilates
☐Biking/Cycling	☐Powerlifting	☐Yoga
☐Swimming	☐Crossfit	☐Stretching
☐Other: ________________		

If you played sports in HS or college, please describe.
What sport(s)?

____

NEUROLOGICAL ASSESSMENT

Which is your dominant hand?…………………………………………………………..	Left	Right
Do you ever have a burning type of pain?..	Yes	No
Do you ever have any numbness or tingling in your arms/hands, legs/feet or face?	Yes	No
Do you currently experience or have a past history of vertigo or balance disorders?	Yes	No
Do you find that your balance is getting worse? …………………………………..…	Yes	No
Do you have a hard time swallowing? ……………………………………………….	Yes	No
Do you have any changes in smell or smell foul things that are not present?.............	Yes	No
Do you have any difficulty with taste or taste things differently than what you are eating?	Yes	No
Have you noticed clumsiness in hand coordination? …………………………..……	Yes	No
Have you noticed uneven sweating or temperature on one side of your body?	Yes	No
Do you ever have any numbness or tingling in your arms/hands, legs/feet or face?	Yes	No
Do you ever have slurred speech?……………………………………………...	Yes	No
Have you noticed any drooping of your eyelids or facial muscles?……….	Yes	No
Do you ever have a fluttering of the eye or noticed you are blinking frequently?	Yes	No

REVIEW OF SYSTEMS

GENERAL, CONSTITUTIONAL

Unexplained weight loss/gain [No][Yes]
Fever [No][Yes]
Night Sweats [No][Yes]
Loss of Sleep [No][Yes]

HEAD, NECK

Headache [No][Yes]
Dizziness [No][Yes]
Fainted Recently [No][Yes]
Head Injury/Concussion [No][Yes]
Loss of Consciousness [No][Yes]
Loss of Memory [No][Yes]

EYES, VISION

Blurry/Double Vision [No][Yes]
Visual Changes [No][Yes]
Tearing/Dryness [No][Yes]
Itching/Redness [No][Yes]

EARS, NOSE, THROAT

Hearing loss [No][Yes]
Ringing in Ears [No][Yes]
Sinus Problems [No][Yes]
Runny Nose [No][Yes]
Nosebleeds [No][Yes]

HEART, CARDIOVASCULAR

High Blood Pressure [No][Yes]
Medicated for Blood Press. [No][Yes]
Chest pain or pressure [No][Yes]
Arrhythmia or palpitations [No][Yes]
Peripheral edema [No][Yes]
Blood clots [No][Yes]
Varicose Veins [No][Yes]
Cramping in thighs [No][Yes]

RESPIRATORY

Cough/Wheezing [No][Yes]
Asthma [No][Yes]
Shortness of breath [No][Yes]

GASTROINTESTINAL

Abdominal pain [No][Yes]
Heartburn [No][Yes]
Constipation [No][Yes]
Diarrhea [No][Yes]
Irritable Bowel [No][Yes]
Bloating/Gas [No][Yes]
Crave Sugary Foods [No][Yes]

GENITOURINARY

Frequent urination [No][Yes]
Blood in Urine [No][Yes]

MUSCULOSKELETAL

Joint Pain [No][Yes]
Join Swelling [No][Yes]
Restricted motion [No][Yes]
Musculoskeletal pain [No][Yes]
Muscle Cramping [No][Yes]

SKIN/INTEGUMENTARY

Rashes [No][Yes]
Sores [No][Yes]

PSYCHIATRIC

Nervousness/anxiety [No][Yes]
Depression [No][Yes]

HEMATOLOGIC/LYMPHATIC

Abnormal bleeding [No][Yes]
Open Wound [No][Yes]
Ankle Swelling [No][Yes]

ALL/IMMUNITY

Allergic reaction [No][Yes]