New Patient Form

Patient Number: _________

Patient Name ______________________________________ Date __________________________

Guardian Name (if under 18) ____

Street Address____

City ________________________________ State _______________ Zip _____________________

Cell # _______________________________ Home # _____________________________________

Email Address: ____
(Parent/Guardian if under 18)

Date of Birth _____/______/______ Age _____ Social Security #___________________________

Your Occupation _______________________ Work Duties _______________________________

How did you hear about the office? ____

Who is your Primary Care Physician ______________________ Phone # ______________________

Referring Physician (if different) __________________________ Phone #______________________

Emergency Contact

Name _________________________________Relationship _______________________________

Contact # ____

Race:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ White
- ☐ Declined to Specify

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Declined to Specify

Smoking Status:
- ☐ Current Every Day Smoker
- ☐ Current Some Day Smoker
- ☐ Former Smoker
- ☐ Never Smoker
- ☐ Decline to Specify

Alcoholic Beverages:
- ☐ Daily
- ☐ Weekends
- ☐ Occasionally
- ☐ Never

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Declined to Specify

Medical History – Section 1

Height: ______________ **Weight:** __________________

Medications ☐ Yes ☐ No **If Yes, please list current medication**

Drug Allergies ☐ Yes ☐ No **If Yes, please list below**

Surgeries ☐ Yes ☐ No **If Yes, please list type and date**

Other Medical History ____

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Medical History – Section 2

1. Do you wear a pacemaker? YES NO
2. Do you have or have had any chest pain without physical activity? YES NO
3. Have you ever been diagnosed with a heart condition? YES NO
4. Do you feel pain in your chest when you do physical activity? YES NO
5. Do you take prescribed drugs for blood pressure or a heart condition? YES NO
6. Have you been advised by a doctor to avoid physical activity? YES NO
7. Do you lose your balance due to dizziness or ever lose consciousness? YES NO
8. Have you ever been diagnosed with cancer and/or had a tumor removed? YES NO
9. Do you have a bone/joint problem that might worsen with physical activity? YES NO
10. Have you had a recent hip or knee replacement? When? ______________ YES NO
11. Do you have any of the following:
    IUD coil________ Metal pins________ Metal bolts________ Metal plates________ NO
12. Are you pregnant or have you given birth less than 6 weeks ago? YES NO
13. Have you had a condition requiring medical attention in the past 8 weeks? YES NO
14. Do you suffer from any of the following conditions?
    Epilepsy_____ Diabetes_____ Severe migraine_____ Detached retina_____ NO
15. Have you ever fractured any bones? YES NO
16. Do you have any episodes of back pain or disc problems? YES NO
17. Have you had any spinal surgeries? YES NO

I understand that these answers are relevant to my care and I have answered them truthfully and to the best of my ability.

Patient Name__________________________________Guardian_____________________________

Signature____Date___________
(Signature of patient or legal guardian required if patient is younger than 18 years old)

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Symptoms:

Please mark **P**, for in the **Past**, **C** for **Currently** have, or **N** for **Never.**

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfunction.
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea or Constipation
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problem
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disability
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping
___ Ulcers	___ Heartburn	___ Heart Problem	___ High Blood Pressure
___ Low Blood Pressure	___ Asthma	___ Difficulty Breathing	___ Lung Problems
___ Kidney Trouble	___ Gall Bladder Trouble	___ Liver Trouble	___ Hepatitis (A,B,C)

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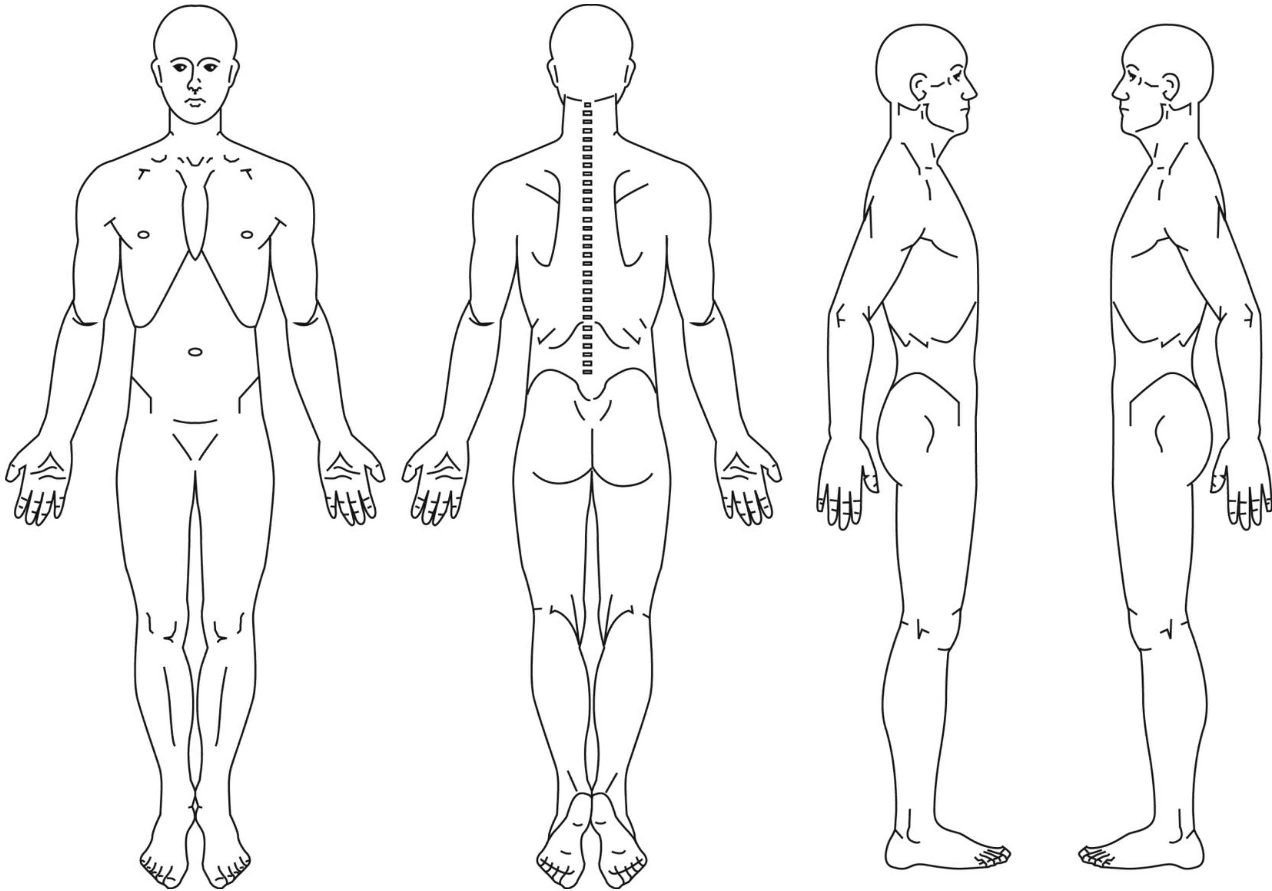
Patient Name: ______________________________Date: ____________________

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:

R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling



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Activities of Daily Life

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sit to Stand	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Climb Stairs	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Pet Care	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Extended Computer Use	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Lift Children/Groceries	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Read/Concentrate	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Getting Dressed	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Shaving	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sexual Activities	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sleep	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Static Sitting	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Static Standing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Yard work	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Walking	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Washing/Bathing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sweeping/Vacuuming	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Dishes	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Laundry	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Garbage	□ No Effect	□ Painful (can do)	□ Painful (limits	□ Unable to Perform
Driving	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform

Other: _______

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