

Welcome To New Life Chiropractic

Who referred you or how did you hear about our office? _____
Have you ever been under chiropractic care before? No Yes. If yes When: _____ Reason: _____

PATIENT DATA (Print Legibly)

Name _____ SS# _____ Email _____
Address _____ City _____ State _____ Zip _____
Phone (Cell) _____ (Home) _____ (Work) _____
Age _____ Birth Date _____ Sex M F Occupation _____ Hrs worked per week _____
Emergency Contact _____ Relationship _____ Phone _____

CURRENT COMPLAINTS

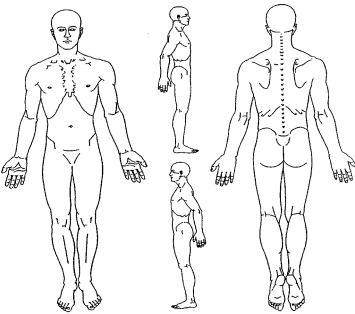
Have you seen other doctors for this condition? No Yes _____

Reason for Visit _____

How long has it been since you really felt good? _____

Is this condition due to an accident? No Yes. If yes what type? Auto Work Home Other _____

Mark an X on the picture where you have pain or discomfort.



When did your symptoms first appear? _____

What caused this complaint or how did you do it? _____

What aggravates or makes the condition worse? _____

Is this condition getting progressively worse: Yes No Uncertain Other _____

What relieves or makes the condition better? _____

Type of pain or discomfort: Sharp Dull Ache Numbness Shooting Tight

Burning Tingling Swelling Stabbing Itching Throbbing Other _____

Overall Frequency of complaint: Constant 100% of the time Frequent 75% Intermittent-50% Occasional-25%

Does it interfere with Work Sleep Daily Routine Recreation Other _____

**Circle the severity of your pain at its BEST and at its WORST.
Use the scale of Zero (no pain) to 10 (severe pain).**

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0	1	2	3	4	5	6	7	8	9	10

What are your hobbies (indoors & outdoors)? _____

How much time each day do you use the computer at work? _____ At home? _____

What makes you stressed? _____ How do you relieve it? _____

List 3 goals you want to achieve through chiropractic care:

1. _____ 2. _____ 3. _____

FINANCIAL AGREEMENT

Do you have health insurance No Yes If yes PPO HMO Other

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and me. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider (New Life Chiropractic) for services rendered. **I clearly understand and agree that all services rendered me are charged directly to me and that I am personally and financially responsible for payment whether or not paid by insurance.**

Patient or Guardian Signature

Date

HEALTH HISTORY

Please check each of the conditions that you have now or had in the past.

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Dizziness/Vertigo | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Shoulder Pain/Tingling |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Feet Pain/Tingling | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Suicidal |
| <input type="checkbox"/> Arm Pain/Tingling | <input type="checkbox"/> Gout | <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hand Pain/Tingling | <input type="checkbox"/> Lower Back Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Headaches | <input type="checkbox"/> Mid Back Problems | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Heart Attack/Stroke | <input type="checkbox"/> Migraines | <input type="checkbox"/> Ulcers/Colitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Surgery/Pacemaker | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Pain that wakes you up at night |
| <input type="checkbox"/> Chemotherapy/Radiation | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> (Men) Prostate Conditions |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hernia | <input type="checkbox"/> Numbness _____ | <input type="checkbox"/> Motor Vehicle Accident |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis/Osteopenia | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Parkinson's Disease | |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Psychiatric Condition | <input type="checkbox"/> Other _____ |

For Women:

- Is there a chance you are Pregnant? No Yes How many weeks? _____
- Are you nursing? No Yes
- Are you taking birth control pills? No Yes
- Do you experience painful periods? No Yes Where is the pain? _____
- Do you suffer from PMS No Yes
- Do you have irregular cycles? No Yes
- Do you have breast implants? No Yes
- Number of pregnancies? _____ Number of births? _____

Injuries/Surgeries you have had:**Description****Date**

Falls _____

Head Injuries _____

Broken Bones/Dislocations _____

Surgeries _____

Lifestyle Habits:

Tobacco (#/day) _____ Coffee (cups/day) _____ Sleep (hrs/day) _____ Water (oz/day) _____

Alcohol* (drinks/day) _____ Tea (cups/day) _____ Soft Drinks (cans/day) _____ Diet or Regular

Exercise: Type _____ Frequency _____

*1 Drink = 1.5oz liquor, or 12oz beer, or 6oz wine

FAMILY HISTORY

Tell us about the major health conditions of your immediate family.

Family Member Relation:**Health Problem:**

MEDICATIONS TAKEN NOW

List prescription, nonprescription, vitamins, minerals, herbs & supplements etc.

Name:**Purpose:****How Long Taken?:**

Your Height _____ Your Weight _____