SALINA
CHIROPRACTIC

PAGE 1 - NEW PATIENT CONFIDENTIAL INFORMATION: **Today's Date**_____

Name – First_____ MI ____ Last_____

Date of Birth _____ **Age** _____ **SS#**_____

Address _____ City _____ State_____ Zip_____

Home Phone _____ **Work Phone** _____ **Cell** _____

I prefer to be called on: ___ Cell ___ Home ___ Work

E-mail address (we never sell e-mail address)_____

___ Married ___ Single ___ Divorced ___ Widowed Spouse Name _____

Primary Care Physician _____ **Most Recent Visit** _____

Your Employer _____ **Job Description** _____

Reason for visit today: _____

Is this related to a: __ work injury __ automobile accident Date of Injury _____

Chief Complaint Today: __ Neck pain __ Lower back pain __ Headaches __ Mid back pain

__ Shoulder pain – L R __ Arm pain – L R __ Leg pain – L R __ Feet pain – L R

__ Other: _____

Pain Level today: 0=no pain 10=severe pain _____

How long have you had this problem? _____

What caused this problem? _____

Does your pain come and go? Or Is the pain constant? ___ comes and goes ___ constant

What makes it worse? __ sitting __ standing __walking __ bending __lifting __driving

__house work __yard work __ weather changes __ Other: _____

What makes it better? __sitting __ standing __walking __ bending __ rest __ice __heat

__ medication __ massage __ sleeping __ other: _____

Have you had this problem in the past? __ no __ yes – When?_____

Does your pain affect your sleep? __no __ yes - __no sleep __ restless sleep __ poor sleep

How do you feel first thing in the morning getting up? __good __ not bad ___ bad

Are you currently taking medication, including over the counter medication, for your pain?

__ No __ Yes – List: _____

Is your problem: ___ staying the same with time ___ getting worse with time __ getting better

Any additional information you would like to report about your chief complaint:

SALINA
CHIROPRACTIC

Page 2 – PATIENT NAME_____ **Date**_____

SECONDARY COMPLAINTS:

I also have: __ neck pain __ headaches __ mid back pain __ lower back pain __ shoulder pains

__arm symptoms __leg symptoms __feet pain __ other: _____

Any information you would like to report about secondary complaints:

Medical History:

Have you seen a chiropractor in the past? __ No __Yes

If yes, when was your last chiropractic treatment? _____

What problem were you treated for? _____

Was your experience: ___ good: treatment helped ___not good: treatment did not help

What did you like? _____

What did you not like? _____

Current Medical Problems:

__ High blood pressure __ heart disease __ arthritis __ thyroid problems __ digestive problems

__ asthma __ cancer __ AIDS / HIV __ alcoholism __ chemical dependency __osteoporosis

__diabetes __emphysema __hepatitis __multiple sclerosis __ prostate problems

__tuberculosis __ venereal disease __ polio __epilepsy __kidney disease __ liver disease

__ stroke __ psychiatric care __pace maker __metal implants __ depression

__ Other: _____

Have you had any major accidents or injuries in the past? __ No __ Yes
If yes, please describe and note date:

Have you broken any bones in the past? __ no __ yes

If yes, please describe and note dates:

Have you had any surgeries in the past? __ no __ yes

If yes, please list and note dates:

SALINA
CHIROPRACTIC

PAGE 3 - PATIENT NAME_____ **Date**_____

Are you taking any <u>prescription medications</u>? __ no __ yes
If yes, please list or attach list:

Are you taking any <u>over the counter (OTC) medications</u>? __ no __ yes
If yes, please list or attach list:

Do you have any <u>family history</u> of back problems? __no __ yes
If yes, please describe:

<u>Social History:</u>

__ Smoking - ___ packs per day

__ Alcohol - ___ drinks per week

__ Coffee / caffeine drinks - ___ cups / drinks per day

__ High stress level – Cause- _____

__ Exercise: __ never __ rarely __occasional __ regularly __ daily

Females: Are you pregnant? __ No __ Yes __ Possibly

<u>Additional Information:</u>

I am interested in:

__ Finding out what's wrong

__ Chiropractic adjustments - __ traditional __ gentle __ Instrument

__ Spinal Decompression

__ Acupuncture

__ Second opinion

__ I'm scared

__ I have concerns regarding _____

EMERGENCY CONTACT: Name _____ Phone _____ Relationship_____

How were you referred to our office? _____

Patient Signature _____ **Date** _____

THANK YOU FOR CHOOSING OUR OFFICE!