NEW PATIENT ADMITTANCE RECORD

Date_____

Name_____ Street_____ City_____ Zip_____

Home Phone #_____ Work Phone #_____ Age_____ Date of Birth_____ Cell #_____

Marital Status M. S. W. D. E-MAIL: _____

Occupation_____ Company Name_____

Address_____

Spouse (Name)_____ Occupation_____ Company Name_____

Address_____ Telephone #_____

Referred By_____ Previous Chiropractic Care Yes___ No___ If Yes When?_____

1. Please Describe Your Complaint: _____

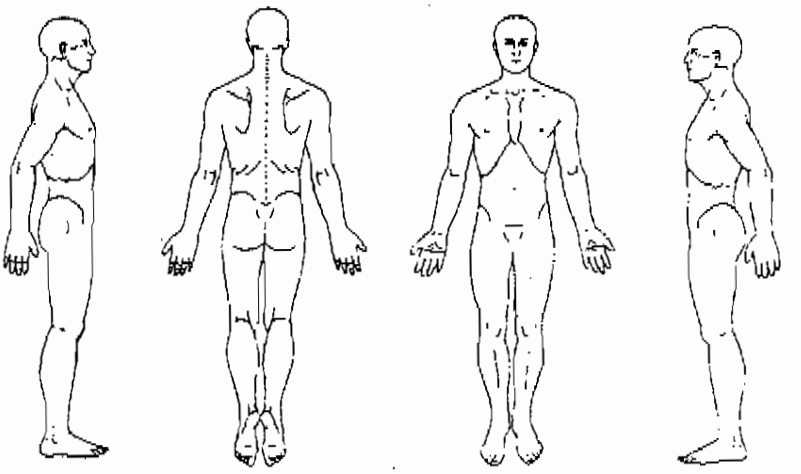
a. Description:

- ☐ Sharp Pain
- ☐ Dull Pain
- ☐ Ache
- ☐ Weak
- ☐ Throbbing
- ☐ Numb
- ☐ Shooting
- ☐ Gripping
- ☐ Burning
- ☐ Tingling

b. Frequency:

- ☐ Constant (76-100%)
- ☐ Frequent (51-75%)
- ☐ Occasional (26-50%)
- ☐ Intermittent (25%or less)

MARK ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



c. Indicate intensity of your pain at its lowest and highest level No Pain ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Unbearable Pain

d. Your symptoms are ☐ decreasing ☐ not changing ☐ increasing

e. Symptoms are worse in the ☐ Morning ☐ Afternoon ☐ Night ☐ Increases during the day ☐ Same all day.

2. When did your problem begin: SPECIFIC DATE IF POSSIBLE? _____ Describe how your problem began: _____

3. Have you been treated *for this episode*? ☐ Yes ☐ No
If yes, by whom? ☐ Chiropractor ☐ MD ☐ Osteopath ☐ Physical Therapist ☐ Occupational Therapist ☐ Other _____
Are you currently being seen? ☐ Yes ☐ No
When and what treatment? __/__/__ _____

4. *In the past* have you been treated for the same or a similar problem? ☐ Yes ☐ No
If yes, who did you see for that episode? ☐ Chiropractor ☐ MD ☐ Osteopath ☐ Physical Therapist ☐ Occupational Therapist ☐ Other _____
When and what treatment did you receive? _____

5 What makes your problem better? ☐ Nothing ☐ Lying down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity

6. What makes your problem worse? ☐ Nothing ☐ Lying down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity

Do your symptoms interfere with:_____ Work _____ Sleep _____ Daily activities _____ Other

Are you able to work? _____ Yes _____ No If no, please describe what type of work you do:

Sitting Standing Walking Lifting Bending Carrying

NEW PATIENT **page 2**

Patient Name _____ **Date** _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ][ ][ ] Weight [ ][ ][ ] lbs.
Feet Inches

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
○	○	Headaches	○	○	High Blood Pressure	○	○	Diabetes
○	○	Neck Pain	○	○	Heart Attack	○	○	Excessive Thirst
○	○	Upper Back Pain	○	○	Chest Pains	○	○	Frequent Urination
○	○	Mid Back Pain	○	○	Stroke			
○	○	Low Back Pain	○	○	Angina	○	○	Smoking/Use Tobacco Products
						○	○	Drug/Alcohol Dependence
○	○	Shoulder Pain	○	○	Kidney Stones			
○	○	Elbow/Upper Arm Pain	○	○	Kidney Disorders	○	○	Allergies
○	○	Wrist Pain	○	○	Bladder Infection	○	○	Depression
○	○	Hand Pain	○	○	Painful Urination	○	○	Systemic Lupus
			○	○	Loss of Bladder Control	○	○	Epilepsy
○	○	Hip/Upper Leg Pain	○	○	Prostate Problems	○	○	Dermatitis/Eczema/Rash
○	○	Knee/Lower Leg Pain				○	○	HIV/AIDS
○	○	Ankle/Foot Pain	○	○	Abnormal Weight Gain/Loss			
			○	○	Loss of Appetite	***Females Only***		
○	○	Jaw Pain	○	○	Abdominal Pain	○	○	Birth Control Pills
			○	○	Ulcer	○	○	Hormonal Replacement
○	○	Joint Swelling/Stiffness	○	○	Hepatitis	○	○	Pregnancy
○	○	Arthritis	○	○	Liver/Gall Bladder Disorder	○	○	
○	○	Rheumatoid Arthritis						
			○	○	Cancer	***Other Health Problems/Issues***		
○	○	General Fatigue	○	○	Tumor	○	○	
○	○	Muscular Incoordination				○	○	
○	○	Visual Disturbances	○	○	Asthma	○	○	
○	○	Dizziness	○	○	Chronic Sinusitis			

ndicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ _____

.ist all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

lst all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

atient Signature _____ ***Date*** _____

Provider's Additional Comments

_____

_____

_____

octors Signature _____ ***Date*** _____