Power Chiropractic

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New Patient Information

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

Address: _____ **City:** _____**State:** _____**Zip:**_____

Weight_____ **Height**_____ **Phone:** _____ **Cell:** _____

Best Time to Call: _____**Which #**_____ **Email:** _____

Social Security # _____/_____/_____**DOB:**_____ **Family Doctor:** _____

□ **Married** □ **Single** □ **Sep** □ **Divorced** □ **Widowed** **Spouse's Name:** _____

Employer: _____ **Spouse's Employer:** _____

Employers Phone: _____**Parents Employer if Patient is Minor/Child:** _____

Parents SS # if Patient is Minor/Child: (required) _____**Emergency Contact**_____

Relationship to Minor/Child: _____ **Phone:** _____

Who may we thank for referring you to our office: _____

SYMPTOM SURVEY

What is your chief problem or symptoms? _____

What caused the problem or symptom to occur? _____

When did the problem or symptom begin? _____

Have you seen another doctor for this problem? □ **NO** **If yes, who?** _____

What test/procedures have been performed? □ **X-Ray** □ **MRI** □ **Surgery** □ **Hospitalization** □ **Other**_____

Have you had this problem or symptoms in the past? □ **NO** **If yes explain**_____

Have you tried any other treatments for this? □ **NO** **If yes explain**_____

Is the problem or symptoms getting worse? □ **NO** **If yes explain**_____

PLEASE PROVIDE US WITH A COPY OF YOUR DRIVERS LICENSE AND INSURANCE CARDS

✓ ALL OF THE ITEMS THAT APPLY TO YOU NOW AND IN THE PAST:

□ Arthritis	□ Depression	□ Pregnancy	□ Seasonal Allergies	□ Eye Pain-Strain
□ Dizziness/Balance	□ Ringing in the Ears	□ Seizures	□ Blurred Vision	□ Anxiety
□ Elevated Stress	□ Fears/Trauma	□ Headache	□ Bleeding Gums	□ Jaw Pain
□ Chronic Fatigue	□ Heart Disease	□ Gall Stones	□ Swallowing Difficulty	□ Thyroid Problem
□ Chest Pain	□ Chest Congestion	□ Anemia	□ Hypertension	□ Difficulty Walking
□ Kidney Stones	□ Diabetes	□ Pancreatitis	□ Sleep Disruption	□ Irregular Heart beat
□ HIV/AIDS	□Asthma/Bronchitis	□ Gout	□ Neck Pain/Spasm	□ Stroke
□ Mid-Back Pain	□ Should/Elbow Pain	□ Wrist/Hand Pain	□ Low Back Pain	□ Hip/Knee/Leg Pain
□ Foot/Ankle Pain	□ Abdominal Pain	□ Groin/Rectal Pain	□ Female Disorder	□ Urinary Problems
□ Skin Problems	□ Broken Bones	□ Digestive Problems	□ Nausea-Vomiting	□ Irregular Bowels

PATIENT & FAMILY HISTORY

What is your occupation? _____ □ Full Time □ Part Time

What is your employment status? □ Working □ Sick Leave □ Unemployed □ Retired □ Temporary Disability
□ Permanent Disability Last day of work_____

Do you use tobacco? □ NO □ YES Explain: _____

Do you consume alcohol? □ NO □ YES Explain: _____

Do you have a history of substance abuse? □ NO □ YES Explain: _____

List all Past Surgeries _____

List all Drug Allergies _____

List all current and past medications/drugs _____

Drug Name: _____ _____

List all Physicians you have seen in the past 5 years?

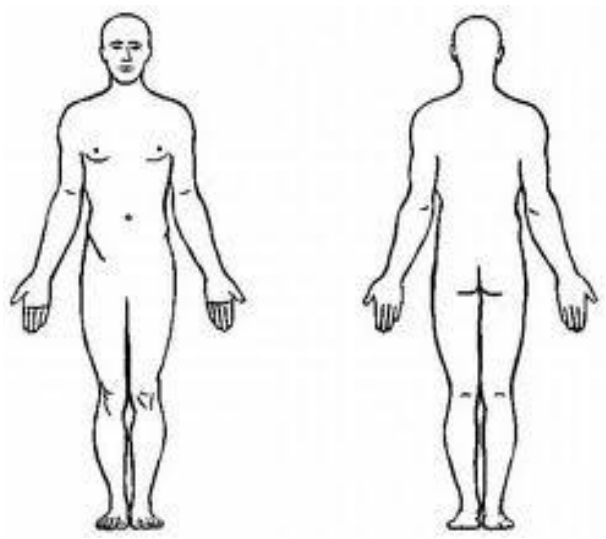
Name: _____ For What: _____
Name: _____ For What: _____
Name: _____ For What: _____

Father □ Living Age: _____ □ Deceased-Cause of Death: _____
Mother □ Living Age: _____ □ Deceased-Cause of Death: _____
Brother □ Living Age: _____ □ Deceased-Cause of Death: _____
Brother □ Living Age: _____ □ Deceased-Cause of Death: _____
Sister □ Living Age: _____ □ Deceased-Cause of Death: _____
Sister □ Living Age: _____ □ Deceased-Cause of Death: _____

PAIN DRAWING

Circle location(s) of your symptoms on body drawing. Outline using the symbols for the type of sensation

Describe your pain below (check all that apply)



R L L R

Pain XXXX

Numbness +++++

Burning //////////

Ache ***

Pins and Needles or tingling ----------

□ Recurring **□ Tingling**
□ Stabbing **□ While Resting**
□ Dull Ache **□ Daily/Constant**
□ Sharp **□ Deep Ache**
□ Throbbing **□ During Exercise/Work**
□ Nightly/Sleeping **□ Other_____** **Onset of Pain: □ Sudden □ Gradual**

On a scale of 1 to 10 how would you rate your pain level today? _____ (1=Mild, 10=Intense)

ATTESTATION STATEMENT

By signing my name below, I agree that I have answered these above questions to the best of my acknowledgment and I have had read to me or I have read and and fully understand these questions as it relates to my health.

Patient Signature: _____Date:_____

Doctor Signature: _____ Date: _____