New Patient Information

Please print clearly

Date: _______/________/__________

Patient Name: ______________________________________ Sex: ❑ Male ❑ Female

Last *First* *M.I.*

Address: ____

Street *City* *State* *Zip*

Parent or Guardian (if patient is a minor): ________________________________

Is patient employed? ❑ Yes ❑ No ❑ Full-time student Occupation: _____________

Employer or School: ____________________ Marital Status: ❑ Married ❑ Single ❑ Other

Home Phone: (______) _____-______ Work Phone: (_____) _____-______ ext. ______

E-mail: ____

Date of Birth: _____/_______/________ SS#: ________-________-__________

Primary Care Dr.: ____

How did you hear about our office?_______________________________________

EMERGENCY CONTACT (not living with patient): _____________________________

Phone: (_____) ______-_________ Relationship: ________________________

Insurance Information:

Primary Insurance Co: ____

Group #: ____________________ Policy I.D./Claim #.: ________________________

Is patient the subscriber? ❑Yes ❑ No **If no, then**:

Subscriber's Name:_______________________ Subscriber's Employer: ____________________

Relationship to Patient:____________________ Subscriber Date of Birth: _____/_____/_____

In Order to Bill Your Insurance, We Must Have a Copy of Your Insurance Card.

Injury Information:

Condition is related to: ❑ Work ❑ Auto ❑ Home ❑ Sports ❑ Other ❑ None

Date of injury/onset of condition: _________/_________/______________

Body side: ❑ Right ❑ Left ❑ Both Body part affected: _____________________

Attorney or Claims Manager or Vocational Rehab Counselor:

Name: ________________________________ Phone (_______)_______-_____________

E-mail: _________________________________ Fax (______) ________-_____________

Address: ____

Street *City* *State* *Zip*

For Office Use Only

Therapist: ____________________ DC Number: ____________________

Dx Codes: ____

Integrated Center for Optimum Health, LLC

Integrated Center for Optimum Health, LLC

(Confidential)

Patient Name: ___________________________________ **Today's Date**: _____________

What problem are you here for today? ____

*Mark an **X** below where you continue to have pain, numbness or tingling*

Pain information.

	Yes	No
Throbbing	❑	❑
Sharp	❑	❑
Aching	❑	❑
Tingling	❑	❑
Burning	❑	❑
Numbness	❑	❑
Shooting	❑	❑

Rate your current pain intensity (Please circle) ***0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 -----10***

*How often do you have this pain?*____

The pain is: ❑ Constant ❑ Comes and goes

Does it interfere with your: ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation

Which activities increase your symptoms?

❑ Sitting ❑ Twisting ❑ Lifting ❑ Rising
❑ Walking ❑ Standing ❑ Bending ❑ Other:____________
❑ Driving ❑ Reaching ❑ Squatting
❑ Kneeling ❑ Reclining ❑ Stairs

Is your condition overall:

❑ Improving ❑ Getting worse ❑ Staying the same

Have you had any treatment for this problem in the past? ❑ Yes ❑ No

What treatment have you already received for your condition? ❑ Medications ❑ Surgery
❑ Physical Therapy ❑ Chiropractic Services ❑ None ❑ Other___________________________

*Name and address of other doctor(s) who have treated you for your condition:*________________

____

____

Date of Last:

Physical Exam___________ Spinal X-Ray___________ Blood Test_____________
Spinal Exam_____________ Chest X-Ray____________ Urine Test______________
Dental X-Ray____________ MRI, CT-Scan, Bone Scan_______________________________

Integrated Center for Optimum Health, LLC

(Confidential)

Patient Name: ___________________________________ **Today's Date**: __________

Describe how/when your problem occurred:____

____

____

Have you had a similar problem previously? ❑ Yes ❑ No

Specifics: ____

How would you describe your overall health?

❑ Poor ❑ Fair ❑ Good ❑ Excellent

What is your present: Height _____________ Weight _____________ lbs.

How would you describe your exercise level?

❑ None ❑ Moderate ❑ Daily ❑ Heavy

Are you able to continue your recreational or sporting activities? ❑ Yes ❑ No

Specifics:____

Are you able to continue working? ❑Yes ❑ No

If no, when did you last work? ____

Are the physical demands of your job? ❑ Light ❑ Moderate ❑ Heavy

During work what do you normally do? ❑ Sit ❑ Stand

What are your goals and expectations for chiropractic treatment?_____________________

____

____

____

____

Confidential Health History

Name______________________________ Date__________________

Age__________ Birthdate______________ Date of Last Physical Examination ______________

What is the reason for your visit? ______________________________________

Symptoms

Check (✓) conditions you currently have or have had in the past year.

General
- ❑ Chills
- ❑ Depression
- ❑ Dizziness
- ❑ Fainting
- ❑ Fever
- ❑ Forgetfulness
- ❑ Headache
- ❑ Loss of sleep
- ❑ Loss of weight
- ❑ Nervousness
- ❑ Numbness
- ❑ Sweats

Muscle/Joint/ Bone
Pain, weakness, numbness in:
- ❑ Arms
- ❑ Hips
- ❑ Back
- ❑ Legs
- ❑ Feet
- ❑ Neck
- ❑ Hands
- ❑ Shoulders

Genito-Urinary
- ❑ Blood in Urine
- ❑ Frequent urination
- ❑ Lack of bladder control
- ❑ Painful urination

Gastrointestinal
- ❑ Appetite poor
- ❑ Bloating
- ❑ Bowel changes
- ❑ Constipation
- ❑ Diarrhea
- ❑ Excessive hunger
- ❑ Excessive thirst
- ❑ Gas
- ❑ Hemorrhoids
- ❑ Indigestion
- ❑ Nausea
- ❑ Rectal bleeding
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Vomiting blood

Cardiovascular
- ❑ Chest pain
- ❑ High blood pressure
- ❑ Irregular heart beat
- ❑ Low blood pressure
- ❑ Poor circulation
- ❑ Rapid heart beat
- ❑ Swelling ankles
- ❑ Varicose veins

Eye, Ear, Nose, Throat
- ❑ Bleeding gums
- ❑ Blurred vision
- ❑ Crossed eyes
- ❑ Difficulty swallowing
- ❑ Double vision
- ❑ Earache
- ❑ Ear discharge
- ❑ Hay fever
- ❑ Hoarseness
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Persistent cough
- ❑ Ringing in ears
- ❑ Sinus problems
- ❑ Vision – Flashes
- ❑ Vision – Halos

Skin
- ❑ Bruise easily
- ❑ Hives
- ❑ Itching
- ❑ Change in moles
- ❑ Rash
- ❑ Scars
- ❑ Sore that won't heal

MEN only
- ❑ Breast lump
- ❑ Erection difficulties
- ❑ Lump in testicles
- ❑ Penis discharge
- ❑ Sore on penis
- ❑ Other

WOMEN only
- ❑ Abnormal Pap smear
- ❑ Bleeding between periods
- ❑ Breast lump
- ❑ Extreme menstrual pain
- ❑ Hot flashes
- ❑ Nipple discharge
- ❑ Painful intercourse
- ❑ Vaginal discharge
- ❑ Other

Date of last menstrual period:

____

Date of last Pap Smear ______________

Have you had A mammogram? __________

Are you pregnant? __________

Number of children __________

Symptoms

Check (✓) conditions you currently have or have had in the past year.

- ❑ AIDS
- ❑ Alcoholism
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorders
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herpes
- ❑ High Cholesterol
- ❑ HIV Positive
- ❑ Kidney Disease
- ❑ Live Disease
- ❑ Measles
- ❑ Migraine Headaches
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Pacemaker
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problem
- ❑ Psychiatric Care
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid problem
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Venereal Disease

Medications List medications that you are currently taking

____

____

____

Pharmacy Name: ______________ **Phone**: ______________

Allergies

____

____

____

____

Family History

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check if your blood relatives had any of the following

✓	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

*Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ❑ Yes ❑ No
If yes, please give approximate dates: ______________________________

Serious Illness/Injuries	Date	Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications, if any

Health Habits

Check (✓) which substances you use and describe how much you use

✓	Substance	How much
	Caffeine	
	Tobacco	
	Drugs	
	Other	

Occupational

Check (✓) if your work exposes you to the following:

✓	Exposure
	Stress
	Heavy Lifting
	Hazardous Substances
	Other

Occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor/therapist or any members of her/his staff responsible for any errors or omissions that I may have made in the completion of this form.

______________________________ Signature ______________ Date

______________________________ Reviewed By ______________ Date