NEW PATIENT MEDICAL FORM

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Date of Birth: _____ Gender: _____ Height: _____ Weight: _____

Social Security Number: _____

Name of your employer: _____

Type of Work: _____

Circle If You Are: Single Married Widowed Divorced Separated

Name and telephone number of person to contact in case of emergency:

_____

Name of husband or wife: _____

Husband or wife's employer: _____

Referred to this office by: _____

LIST YOUR MAJOR PRESENT HEALTH COMPLAINT (IN ONE SENTENCE): _____

_____

DURATION OF PRESENT CONDITION (HOW LONG): _____

Have you been treated before for this problem? ❑ No ❑ Yes

If yes, by ❑ Physician ❑ Chiropractor ❑ Physical Therapist ❑ Osteopath

❑ Other: _____

What did they do and/or recommend? _____

What was their diagnosis? _____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Unknown

CIRCLE ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST:

Alcoholism
Anemia
Appendicitis
Arthritis
Breast Lumps
Cancer
Chicken Pox
Diabetes
Diphtheria
Eczema
Epilepsy
Goiter
Gout
Heart Disease
Hepatitis
High Cholesterol
Hernia
Influenza
Kidney Disease
Liver Disease
Lumbago
Malaria
Measles
Mental Disorders
Migraine Headaches
Multiple Sclerosis
Mumps
Pacemaker
Pleurisy
Polio
Pneumonia
Rheumatic Fever
Scarlet Fever
Stroke
Smallpox
Tuberculosis
Typhoid Fever
Ulcers
Venereal Infection
Whooping Cough
OTHER: _____

Please underline all of the following symptoms you have had PREVIOUSLY.
Please circle all of the following symptoms you have NOW.

GENERAL SYMPTOMS

Headache Fever
Chills
Sweats
Fainting
Dizziness
Convulsions
Numbness or pain in arms, hands, or legs
Allergy
Wheezing
Weight gain
Loss of weight
Loss of sleep
Bruises easily
Neuralgia

E.E.N.T.

Failing vision
Nearsightedness
Farsightedness
Crossed eyes
Eye pain
Deafness
Earache
Ear noises
Ear discharge
Nosebleeds
Nasal obstruction
Sore throat
Hoarseness
Ksthma
Dental decay
Gum trouble
Frequent colds
Enlarged thyroid
Tonsillitis
Sinus infection
Nasal drainage
Enlarged glands
Hay fever

SKIN

Skin eruptions
Itching
Dryness
Boils
Varicose veins
Sensitive skin
Hives or allergy
Sore that wouldn't heal

RESPIRATORY

Chronic cough
Spitting up phlegm
Spitting up blood
Chest pain
Difficulty breathing

CARDIOVASULAR

Rapid heartbeat
Slow heartbeat
High blood pressure
Low blood pressure
Pain over heart
Previous heart stroke
Hardening of arteries
Swelling of ankles
Poor circulation
Paralytic stroke
Chest pain

GENITOURINARY SYMPTOMS

Frequent urination
Painful urination
Blood in urine
Pus in urine
Kidney infection or stones
Bed wetting
Inablity to control urine
Prostate trouble

GASTRO-INTESTINAL

Poor appetite
Difficult digestion
Excessive hunger
Belching or gas
Nausea
Vomiting
Vomiting of blood
Pain over stomach
Distention of abdomen
Constipation
Diarrhea
Colon trouble
Hemorrhoids (piles)
Intestinal worms
Liver trouble
Gall bladder trouble
Jaundice
Colitis

FOR MEN ONLY

Breast lumps
Erection difficulties
Lump in testicle
Penis discharge
Sore on penis
Other: _____

FOR WOMEN ONLY

Are you pregnant? ___
Excessive flow
Hot flashes
Irregular cycle
Cramps or backache
Previous miscarriage
Vaginal discharge
Lumps in breast
Menopausal symptoms
Painful menstrualperiods
Other: _____

NECK, BACK, EXTREMITIES :

Please underline any symptoms you have had previously.
Please circle any you have NOW.

NECK

Pain in neck
Neck stiffness
Neck weakness
Pinched nerve in neck
Neck feels out of place
Muscle spasms in neck
Grinding/popping sounds in neck

SHOULDERS

Pain in shoulder joint ❑ right ❑left
Pain across shoulders
Can't raise arm ❑right left
❑Above shoulder level
❑Over head
Tension in shoulders
Pinched nerve in shoulder ❑right left

MID-BACK

Mid-back pain
Mid-back stiffness
Pain between shoulder blades
Pain from front to back
Muscle spasms in mid-back

LOW BACK

Low back pain
Low back stiffness
Low back weakness
Pinched nerve in low back
Low back feel out of place
Muscle spasms in low back

ARMS & HANDS

Pain in upper arm	❑right	❑left
Pain in elbow	❑right	❑left
Pain in forearm	❑Ought	❑left
Pain in hand	❑right	❑left
Pain in fingers	❑right	❑left
Pins & needles in fingers	❑right	❑left
Numbness in arm	❑right	❑left
Numbness in fingers	❑right	❑left
Weakness of arm	❑right	❑left
Weakness of hand	❑right	❑left
Hands cold	❑right	❑left

HIPS, LEGS & FEET

Pain in buttocks	❑right	❑left
Pain in hip joint	❑right	❑left
Pain down leg	❑right	❑left
Pain in ankle	❑right	❑left
Pain in foot	❑right	❑left
Weakness of leg	❑right	❑left
Weakness of knee	❑right	❑left
Leg cramps	❑right	❑left

OTHER SYMPTOMS

_____
_____
_____
_____

PAST HEALTH HISTORY

OPERATIONS/SURGERIES AND YEARS PERFORMED: _____

_____

_____

VACCINATIONS AND INJECTIONS RECEIVED:

❑Diphtheria ❑Polio ❑Tetanus ❑Spinal tap or Injection ❑Typhoid ❑Smallpox
❑Other _____

HABITS: ❑Coffee ❑Tea ❑Alcohol ❑Tobacco ❑
❑Excercise ❑Hobbies ❑Sleep (Hours) _____

OTHER MEDICAL HISTORY: _____

_____

ACCIDENTS OR FALLS (Please Describe): _____

_____

FRACTURES OR DISLOCATIONS: _____

DRUGS (MEDICATIONS) YOU ARE CURRENTLY TAKING:_____

Have you ever had a nervous breakdown?_____

Have you ever been treated for mental disorders?_____

Has any member of your family been treated for a mental disorder? _____

FAMILY HEALTH HISTORY

RELATION	NAME	AGE	SIGNIFICANT ILLNESSES
FATHER			
MOTHER			
BROTHER			
BROTHER			
SISTER			
SISTER			
CHILD			
CHILD			
CHILD			

ANY ADDITIONAL INFORMATION YOU FEEL WE SHOULD KNOW PLEASE ADD HERE:

_____

_____

_____

_____

FINANCIAL RESPONSIBILITY

Who is responsible for your bill: ❑self ❑insurance ❑employer (worker's comp) ❑automobile ins.
❑Father _____

Policy holders name (if different from yourself) _____

Policy holders date of birth: _____

Any charges not covered by insurance are the responsibility of the patient. The patient is responsible for meeting the payment requirements of the insurance policy regarding deductibles and co-payments, and also payment for services not covered by the insurance policy

_____ _____

PATIENTS SIGNATURE **DATE OF SIGNATURE**

IF PATIENT IS A MINOR, PARENT OR LEGAL GUARDIAN MUST SIGN FORM