

New Patient Information

Welcome To Our Office

Name _____ Preferred Name _____

Address _____

City/State/Zip _____

Home Phone# _____ Cell Phone# _____

Work Phone # _____ Is it okay to contact you at work? yes no

Your email will NOT be shared with any 3rd parties, and is used for general office announcements.

Email Address _____

SS# _____ Birthdate _____ Age _____

Occupation _____ Employer _____

Marital Status Single Married Separated Divorced Widowed

Spouse's Name _____ Phone #(s) _____

Children's Names and Ages _____

Do you have any pets? yes no If yes, please tell us what kind(s) _____

Favorite hobbies or interests _____

Emergency contact: Name _____

Relationship _____ Phone #(s) _____

What Brings You Here?

Have you ever had chiropractic care before? yes no

If yes, when was the last time you were adjusted? _____

If yes, please tell us the doctor's name _____

Were you pleased with the care? yes no

How did you find out about our office? _____

Is this appointment related to work sports auto

personal Injury other _____

When did the incident occur? _____

Attorney (if applicable) _____ Phone # _____

Are you receiving care from other health professionals? yes no

If yes, please name them and their specialty _____

Please list any drugs or medications you are taking _____

Please list any vitamins/herbs/homoeopathic/other you are taking _____

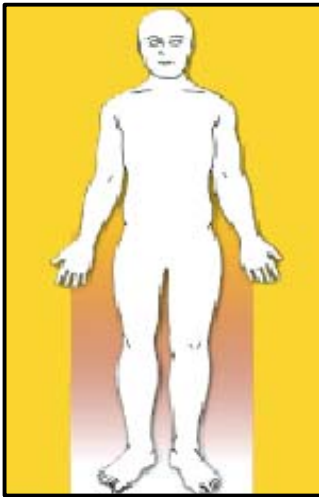
Current History

What are your most pressing health concerns? _____

For how long? _____

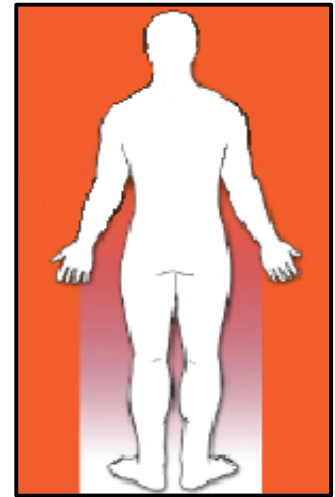
Is it: getting worse improving intermittent
 constant can't say

Where is the problem? Please use the illustrations and lines below to explain.



Front _____

Back _____



Do you have: pain numbness tingling aches
Is your pain: sharp dull throbbing constant intermittent

Are your symptoms affected by:

sitting standing walking
 bending lying down weather

Please explain: _____

Do you feel:

cramps burning swelling
 stiffness other _____

Do your symptoms interfere with:

work sleep day-to-day activities
 play other _____

Please explain: _____

On a scale of 1-10 (1 least, 10 most), please rate:

The severity of your symptoms 1 2 3 4 5 6 7 8 9 10

Are you Pregnant? yes no If yes, what month? _____

If applicable, date of last menstrual period _____

Health History

Do you have, or have you had, any of the following (please check all that apply)

- | | | | | |
|------------------------------------|----------------------------------|-------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> pneumonia | <input type="checkbox"/> mumps | <input type="checkbox"/> influenza | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> smallpox |
| <input type="checkbox"/> pleurisy | <input type="checkbox"/> polio | <input type="checkbox"/> chickenpox | <input type="checkbox"/> thyroid disease | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> epilepsy | <input type="checkbox"/> cancer | <input type="checkbox"/> depression | <input type="checkbox"/> whooping cough | <input type="checkbox"/> anemia |
| <input type="checkbox"/> eczema | <input type="checkbox"/> measles | <input type="checkbox"/> arthritis | <input type="checkbox"/> heart disease | <input type="checkbox"/> rashes |

If you have ever been diagnosed with another disease or condition, please describe _____

- Do you use:
- | | | | |
|----------------------------------|-------------------------------------|--|--------------------------------|
| <input type="checkbox"/> coffee | <input type="checkbox"/> tea | <input type="checkbox"/> artificial sweeteners | <input type="checkbox"/> sugar |
| <input type="checkbox"/> alcohol | <input type="checkbox"/> cigarettes | <input type="checkbox"/> recreational drugs | |

Have you ever suffered from (please check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> neck pain | <input type="checkbox"/> stuffy nose | <input type="checkbox"/> discolored urine |
| <input type="checkbox"/> low back pain | <input type="checkbox"/> allergies | <input type="checkbox"/> gas/bloating after meals |
| <input type="checkbox"/> headaches | <input type="checkbox"/> fainting | <input type="checkbox"/> heartburn |
| <input type="checkbox"/> migraines | <input type="checkbox"/> weight loss | <input type="checkbox"/> colitis |
| <input type="checkbox"/> arm pain/tingling | <input type="checkbox"/> poor appetite | <input type="checkbox"/> irritable bowel |
| <input type="checkbox"/> shoulder pain | <input type="checkbox"/> excessive appetite | <input type="checkbox"/> black or bloody stools |
| <input type="checkbox"/> hand pain/tingling | <input type="checkbox"/> nervousness | <input type="checkbox"/> constipation |
| <input type="checkbox"/> leg pain/tingling | <input type="checkbox"/> confusion | <input type="checkbox"/> hemorrhoids |
| <input type="checkbox"/> jaw pain | <input type="checkbox"/> depression | <input type="checkbox"/> liver problems |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> dental problems | <input type="checkbox"/> stroke |
| <input type="checkbox"/> lung problems | <input type="checkbox"/> excessive thirst | <input type="checkbox"/> paralysis |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> frequent nausea | <input type="checkbox"/> tingling |
| <input type="checkbox"/> abnormal blood pressure | <input type="checkbox"/> vomiting | <input type="checkbox"/> numbness |
| <input type="checkbox"/> irregular heartbeat | <input type="checkbox"/> prostate problems | <input type="checkbox"/> fatigue |
| <input type="checkbox"/> ankle swelling | <input type="checkbox"/> breast pain/lump | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> cold extremities | <input type="checkbox"/> cramps | <input type="checkbox"/> loss of sleep |
| <input type="checkbox"/> blurred vision | <input type="checkbox"/> painful urination | <input type="checkbox"/> difficulty hearing |
| <input type="checkbox"/> vision problems | <input type="checkbox"/> bladder trouble | <input type="checkbox"/> ear pain |
| <input type="checkbox"/> difficulty breathing | <input type="checkbox"/> excessive urination | |

If yes to any of the above, please describe and date of incident: _____

Past injuries can affect present health (please check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> falls/accidents | <input type="checkbox"/> head injuries | <input type="checkbox"/> fights |
| <input type="checkbox"/> sports injuries | <input type="checkbox"/> broken bones | <input type="checkbox"/> dislocations |
| <input type="checkbox"/> spinal tap | <input type="checkbox"/> surgery | <input type="checkbox"/> traction |
| <input type="checkbox"/> use(d) a cane or walker | <input type="checkbox"/> extensive dental work | <input type="checkbox"/> dental appliances |
| <input type="checkbox"/> knocked unconscious | <input type="checkbox"/> wear orthotics | |

If yes to any of the above, please describe and date of incident: _____

Family History

Family Member | Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

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What Do You Know About Chiropractic?

In your own words, what do chiropractors do? _____

Do you know what spinal nerve stress/subluxation is? yes no

If yes, please describe _____

Do any friends or relatives see chiropractors? yes no

If yes, do they use chiropractic for health maintance/optimization

health problems both

Are you seeking chiropractic for health maintance/optimization

health problems both

What would you like to gain from chiropractic care? _____

Are there other health concerns or anything else you'd like us to know about you?

yes no If yes, please tell us: _____

Financial Responsibility

Who is responsible for payment? _____

How will you pay for your care?

Cash Check Credit Card Medicare Insurance

I understand that Lundquist Chiropractic is not a participating provider of any insurance plans and that my insurance benefits may be reduced or different when rendered by a non participating provider. I also understand that I am financially responsible for all charges whether or not paid by insurance, for all services rendered on my behalf or my dependents.

Authorization

I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. I also agree that the Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

The above is accurate to the best of my knowledge

(signature)

(date)

I, parent/guardian, give permission for minor's care

(signature)

(date)