NEW PATIENT HEALTH FORM

Name______________________________ Nickname______________ Today's Date__________
Address______________________________ City/State/Zip______________________
Home Phone(_____)____________ Work Phone(____)____________ Cell Phone(_____)____________
E-Mail Address______________________________ SS#______________
Birthdate______/______/______ Gender: ☐ Male ☐ Female Height________ Weight________ # of Children______
Occupation__________________ Employer__________________ Referred By______________
Who should we contact in case of emergency?______________ Relationship:__________ Phone(_____)________
Who is responsible for payment? ☐ Self ☐ Spouse ☐ Worker's Comp ☐ Medicaid
☐ Medicare ☐ Auto Insurance ☐ Personal Health Insurance ☐ Other:____________
Is this a wellness checkup? ☐ Yes ☐ NO

1. What is your chief complaint?______________________________
2. When did this complaint begin? (Date)______________________________
3. What caused this problem?______________________________
4. Complaints/Disturbances: ☐ Come and Go ☐ Came on Gradually ☐ Came on Suddenly
5. Symptoms developed from: ☐ Work Related Injury ☐ Auto Accident ☐ Injury other than a Work or Auto Accident
   ☐ Other (explain)______________________________
6. If work related injury, has the injury been reported to your employer? ☐ Yes ☐ No
7. Symptoms are BETTER in: ☐ A.M. ☐ P.M.
8. Symptoms are WORSE in: ☐ A.M. ☐ P.M.
9. Symptoms have persisted for: ☐ Hours ☐ 1 Day ☐ Days ☐ Weeks ☐ Months ☐ Years
10. Have you seen any other doctors for this condition? ☐ Yes ☐ No
    If yes, please list name and address of doctor______________________________
11. What activities make conditions WORSE?______________________________
12. What activities make conditions BETTER?______________________________
13. Have you ever had this condition/problem before? ☐ Yes ☐ No If yes, when?______________
14. Indicate ability to perform the following activities. Use codes: U=Unable, P=Painful, D=Difficult, L=Limited, N=Normal

____Coughing	____Lying on Back	____Sleeping	____Turning over in Bed
____Sneezing	____Lying Flat on Stomach	____Stooping	____Walking Short Distances
____Laughing	____Lying on Side with Knees Bent	____Gripping	____Standing More than One Hour
____Bending Forward	____Dressing Self	____Pushing	____Sexual Activity
____Climbing	____Balancing	____Pulling	____Other__________
____Kneeling	____Reaching	____Sitting at a Table	____Other__________

15. Have you ever been hospitalized and/or had surgery? Please explain:______________________________
    ____
    ____
16. Please list any previous fractures, auto accidents, or bodily injuries______________________________
    ____
17. Please list any medications, prescription or over the counter, oral contraceptives, and vitamins & supplements you are presently taking. Include the prescribing doctor and the amount of each.______________________________
    ____
    ____
18. When did you last have X-rays taken?______________ Where?______________

FAMILY HISTORY:

	DIABETES	HEART	KIDNEY	CANCER	BACK	STROKE
Mother	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐

WOMEN:

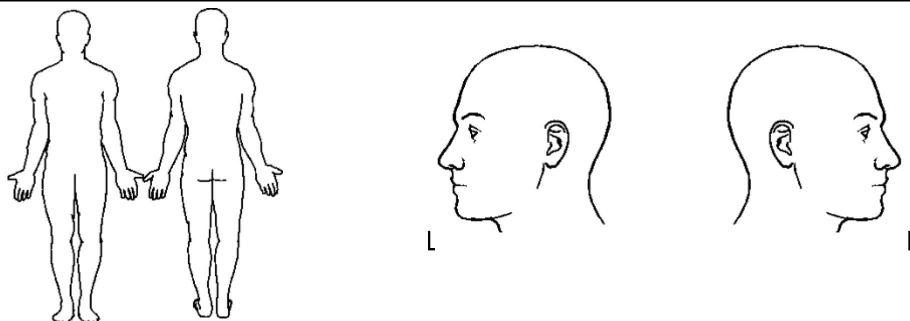
Are you pregnant? ☐ Yes ☐ No ☐ Unsure/Possibly

What was the first day of your last menstrual cycle? (Date) ______________________________

DISCOMFORT AREAS:

Shade and code areas to indicate location of pain or discomfort

USE CODES:
- P=Pain
- S=Spasm
- N=Numbness
- T=Tenderness



CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Aids
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Goiter
- ☐ Rheumatic Fever
- ☐ Malaria
- ☐ Venereal Infection
- ☐ Anemia
- ☐ Mental Disorder
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Scarlet Fever
- ☐ Heart Disease
- ☐ Pneumonia
- ☐ Pleurisy
- ☐ Alcoholism
- ☐ Substance Abuse
- ☐ Epilepsy
- ☐ Mumps
- ☐ Eczema
- ☐ Appendicitis
- ☐ Cancer
- ☐ Typhoid Fever
- ☐ Influenza
- ☐ Polio
- ☐ Tuberculosis
- ☐ Arthritis
- ☐ Measles
- ☐ Whooping Cough
- ☐ ____________

CHECK ANY OF THE FOLLOWING PROBLEMS YOU HAVE OR HAVE HAD IN THE PAST 6 MONTHS:

MUSCLES & JOINTS
- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain/Stiffness
- ☐ Arm/Elbow/Wrist Pain
- ☐ Walking Problems
- ☐ Difficulty Chewing
- ☐ Clicking Jaw
- ☐ Leg/Knee/Foot Pain
- ☐ Hip Pain
- ☐ Pain in Tailbone

NERVOUS SYSTEM
- ☐ Nervousness
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Confusion
- ☐ Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities

EYE, EAR, NOSE & THROAT
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Earaches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose
- ☐ Ringing in Ears
- ☐ Nose Bleeds
- ☐ Sinus Trouble
- ☐ Swollen Glands

GENERAL PROBLEMS
- ☐ Fatigue
- ☐ Night Sweats
- ☐ Frequent Colds
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches
- ☐ Weakness

HEART & LUNGS
- ☐ Wheezing
- ☐ Chest Pain
- ☐ Asthma
- ☐ Short Breath
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Heart Surgery
- ☐ Lung Congestion
- ☐ Coughing
- ☐ Spitting Blood
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Bronchitis

KIDNEY/BLADDER
- ☐ Painful Urination
- ☐ Excessive Urine
- ☐ Discolored Urine
- ☐ Bedwetting
- ☐ Bad Urine Control

STOMACH/INTESTINES
- ☐ Poor Appetite
- ☐ Excessive Appetite
- ☐ Excessive Thirst
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Hemorrhoids/Piles
- ☐ Liver Trouble
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Stomach Cramps
- ☐ Stomach Pain
- ☐ Gas/Bloating
- ☐ Heartburn
- ☐ Black/bloody Stool
- ☐ Colitis
- ☐ Poor Digestion

ALLERGIES
- ☐ Seasonal________________________
- ☐ Allergic Reactions to:________________

MEN
- ☐ Prostate Pain
- ☐ Impotence
- ☐ Infertility

WOMEN
- ☐ Menses Irregular
- ☐ Menstrual Cramps
- ☐ Vaginal Pain
- ☐ Breast Lumps
- ☐ Pain During Sex
- ☐ Difficulty Getting Pregnant
- ☐ Miscarriage

HABITS
- ☐ Smoking – Packs/Day____
- ☐ Alcohol – Drinks/Day____
- ☐ Coffee – Cups/Day____
- ☐ Soda – Cans/Day____
- ☐ Fast Food – Meals/Week___

Patient's Signature____ Date:____________________