NEW PATIENT FORM

Name: □ Mr. □ Mrs. □ Miss. □ Ms □ Dr.

First name: _____ Last Name: _____
Date of Birth: Day- _____ Month- _____ Year- _____ Age- _____
Address: _____
_____
Phone: Home- _____ Cell- _____ Work- _____
Occupation: _____ Email Address: _____
Emergency Contact (Name, Relationship, Contact): _____
_____
Spouse: _____ Children: _____ Pets: _____
Height: _____ Weight: _____ Blood Pressure (if known): _____

Previous chiropractic experience:

Previous chiropractor's name: _____
Previous chiropractor's telephone: _____
Date of last chiropractic visit: _____
Have you been adjusted?: □ Yes □ No
Have you heard the term Subluxation? □ Yes □ No

Patient: _____
Signature

Witness: _____
Signature

How did you hear about us?

□ Website □ Friend/Relative □ Internet
□ Talk/Event □ Signage □ Friend or Relative
□ Other: _____

What is the nature of this visit? □ Health Optimization □ Complaint □ Injury □ Other

I am interested in the following services:

□ Regular Chiropractic □ Neuro-Emotional Technique □ Cranial Adjusting □ Essential Oils
□ Mind-body/Energy Healing Strategies □ Consult to Decrease Chemical Toxins in Lifestyle

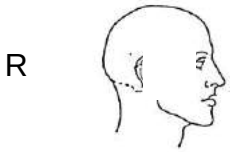
PATIENT SYMPTOMS:

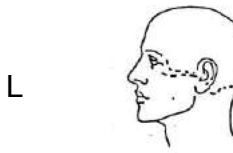
What is your chief complain? _____
When did it start? _____
The complaint is getting: □ WORSE □ BETTER □ SAME
The complaint started: □ SUDDENLY □ GRADUALLY
What may have caused the problem? _____
Duration of symptoms: □ CONSTANT □ HOURLY □ DAILY □ ON & OFF □ INFREQUENT
Is this complaint interfering with any of the following:
▢ Work/financial capacity ▢ Sleep ▢ Daily activities ▢ Sports/exercise ▢ Relationship/family
▢ Hobbies/Interests ▢ Mood ▢ Appetite ▢ Other
Please explain: _____
_____
_____
What Relieves your complaint? _____
What Aggravates your complaint? _____
Has this happened before? □ Yes □ No How? __
Have you had to miss work? □ Yes □ No When? _____
Is the complaint worse at a certain time of day? □ Yes □ No When? _____
Does the weather affect your complaint? □ Yes □ No How? __

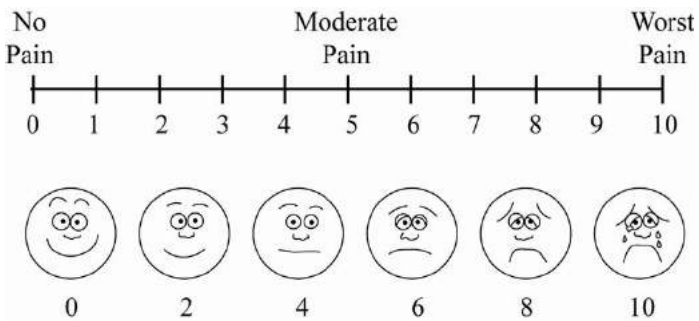
SYMPTOM DIAGRAM: Please fill out the following diagram with the symbols that best represent the sensations you are experiencing with your complaint

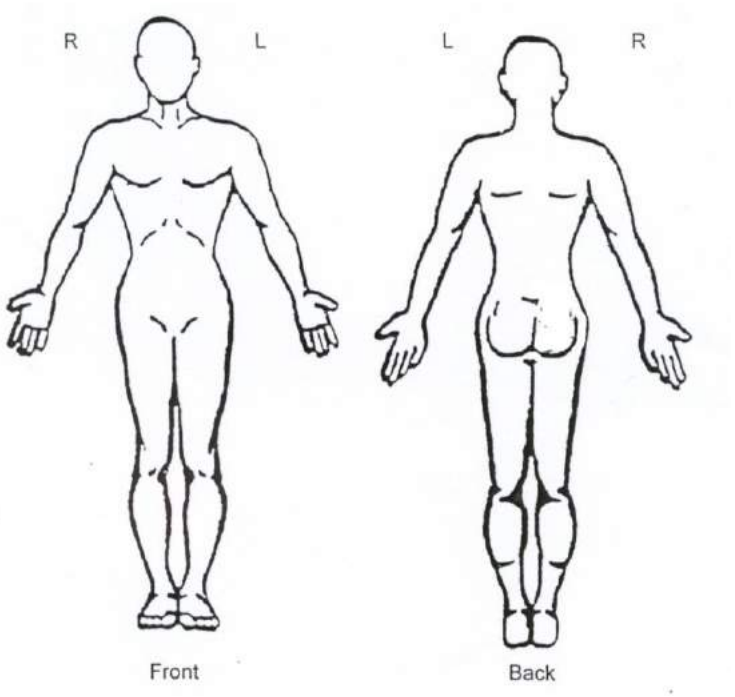
Symbols:

Numbness	=======	Pins and Needles	**ooooo**
Burning	**x x x x x x**	Stabbing & Sharp	~~~~
Dull & Aching	Δ Δ Δ Δ Δ Δ	Stiff & Tight	**2 2 2 2 2**









MEDICAL HISTORY:

Please list all medications you are taking (including over the counter medication like Tylenol, or Advil):

_____

Please list any hospitalizations or surgeries (include year):

_____

Please list any supplements that you are on (include brand if known):

_____

When was the last time you were on antibiotics?
Do you get a cold or respiratory illness often? □Yes □No
Do you smoke? □ Yes □ No How many packs/week? _____
Do you drink alcohol? □ Yes □ No How many drinks/week? _____
Do you have a bleeding disorder? □ Yes □ No
Do you have a heart condition? □ Yes □ No
Do you have a pacemaker? □ Yes □ No
Do you have any allergies? □ Yes □ No If yes, to what? _____
Do you eat fresh organic/pesticide free produce daily? □ Yes □ No
How often do you exercise? □ Daily □ 3-5 days/week □ 1-2 days/week □ Infrequent/Never
What is your energy level? □ Exhausted □ Low □ Good □ Great
Do you have family history of any of the following: □ Heart Disease □ Diabetes □ Arthritis □ Cancer
Explain:

EMOTIONAL STRESSORS:
Have any of the following occurred recently:

▢ Depression	▢ Divorce	▢ Drugs/Alcohol Increase	▢ Anxiety
▢ Death	▢ Change in Job Status	▢ Sleep Disturbances	▢ Family Problems
▢ Increased Work Stress	▢ Chronic Fatigue	▢ Economic Stress	▢ Other

Please comment if appropriate: _____
_____
_____

What is your current level of STRESS? None 1 2 3 4 5 Severe

Do you find a correlation between severity of complaint and times of emotional distress? □ Yes □ No
Explain_____
_____
_____

How well do you cope with stress? □ Poorly □ Okay □ Well

Do you practice meditation, chakra clearing, breath work or other mind-body activities? ▢ Yes ▢ No
Explain_____
_____
_____

Do you have any other coping mechanisms not listed? □ Yes □ No
Explain_____
_____
_____

HEALTH GOALS:

Which of these health goals are the most important to you? Please pick up to 5 and number them from 1 [most important] to 5 [least important]:

▢ **Energy Level and Fatigue** – Do you feel energetic or are you tired of being tired?
▢ **Quality of Sleep** – Do you have difficulty falling or staying asleep?
▢ **Memory and Ability to Focus**
▢ **Digestion** – Do you have problems with reflux, heartburn, bloating, etc.?
▢ **Nutrition** – How healthy is your diet?
▢ **Mood** – Are you happy, anxious, sad, or depressed?
▢ **Stress Levels** – How well are you handling the stresses in your life?
▢ **Allergies and Immune System** – Do you take allergy medication? Are you often sick?
▢ **Understanding more about health and how you and your family can stay healthy**.
▢ **Pain Control/Relief**
▢ **Health Reliability/Stability-** Ability to actively participate in all family/life activities that you need to/want to.

Are there any other health goals or conditions you'd like to work on?

_____

_____

_____

In what ways do you feel that your life is restricted?

_____

_____

_____

What is the best thing that will be added to your life when you regain your health?

_____

_____

_____

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow the doctor to examine me for further evaluation.

Patient/Parent Signature_____Date_____

Dr. Julianne Donato, D.C.
WELL FROM WITHIN
CHIROPRACTIC

HEALTH STATUS SURVEY

General Symptoms
- ☐ Loss of consciousness
- ☐ Blackouts
- ☐ Headache
- ☐ Fever
- ☐ Excess sweating
- ☐ Night sweats
- ☐ Loss of weight
- ☐ Night pain
- ☐ Generalized pain
- ☐ Nervousness
- ☐ Convulsions
- ☐ Loss of sleep

Neurologic
- ☐ Dizziness
- ☐ Fainting
- ☐ Problem speaking
- ☐ Problem swallowing
- ☐ Blurred vision
- ☐ Double vision
- ☐ Nausea
- ☐ Clumsiness
- ☐ Numbness or tingling

Muscles and Joints
- ☐ Sore/stiff neck
- ☐ Mid back ache
- ☐ Low back ache
- ☐ Painful tailbone
- ☐ Shoulder pain
- ☐ Arm/forearm pain
- ☐ Elbow pain
- ☐ Wrist/hand pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Ankle/foot trouble
- ☐ Arthritis
- ☐ Loss of strength

Eyes/Ears/Nose/Throat
- ☐ Failing vision
- ☐ Eye pain
- ☐ Failing hearing
- ☐ Earache
- ☐ Ring/buzz in ears
- ☐ Frequent colds
- ☐ Sinus infection
- ☐ Enlarged thyroid
- ☐ Enlarged glands

Respiratory
- ☐ Asthma
- ☐ Chronic cough
- ☐ Spitting up phlegm
- ☐ Spitting up blood
- ☐ Difficulty breathing

Cardiovascular
- ☐ Bleeding disorder
- ☐ High blood pressure
- ☐ Chest pain
- ☐ Stroke
- ☐ Hardening of arteries
- ☐ Varicose veins
- ☐ Swelling of ankles
- ☐ Poor circulation
- ☐ Heart/blood disease
- ☐ Angina

Genitourinary
- ☐ Trouble urinating
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Bedwetting
- ☐ Prostate trouble

GU for Women
- ☐ Painful menstruation
- ☐ Excessive flow
- ☐ Hot flashes
- ☐ Irregular/absent cycle
- ☐ Cramping/backache
- ☐ Vaginal discharge
- ☐ Swollen breasts
- ☐ Lump in breasts

Currently on birth control pills/patch?
☐ yes ☐ no
Previously on birth control pills/patch?
☐ yes ☐ no
# of pregnancies ____
# of children ____

Skin
- ☐ Rashes/itching
- ☐ Bruise easy
- ☐ Dryness
- ☐ Boils
- ☐ Hives (allergies)

Gastrointestinal
- ☐ Poor appetite
- ☐ Indigestion
- ☐ Excess hunger
- ☐ Belching or gas
- ☐ Vomiting
- ☐ Pain over stomach
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids (piles)
- ☐ Jaundice
- ☐ Gall bladder trouble
- ☐ Intestinal worms
- ☐ Ulcer
- ☐ Diabetes

Have you ever had any fractures?
☐ yes ☐ no
If yes - where?

Have you ever been in a car accident?
☐ yes ☐ no
If yes - when?

Have you ever been hospitalized?
☐ yes ☐ no
Why/When?

Are you currently a smoker?
☐ yes ☐ no How much? _____
Did you smoke previously?
☐ yes ☐ no How much? _____

Have you ever been diagnosed:
With cancer? ☐ yes ☐ no
With HIV/AIDS? ☐ yes ☐ no
With Hep A/B/C? ☐ yes ☐ no

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION
Informed Consent to Chiropractic Treatment

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

1. a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;
2. b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;
3. c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;
4. d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Dated this_____ day of_____, 20_____.

_____ _____

Patient Signature (Legal Guardian) **Witness of Signature**

Name:_____ **Name: _____**

(Please print) **(Please print)**