Maximized Health CHIROPRACTIC

# NEW PATIENT FORMS - ADULT

Please print clearly

## GENERAL INFORMATION (please complete in detail, all information is confidential)

Patient Last Name: ______________________________ First Name: ______________________________ MI: ___

Address: ____________________________________________________

City: ______________________________ State: ______ Zip: __________

Phone (Home): ______________________________________________

Email: _____________________________________________________

Phone (Work): __________________ Phone (Cell): _________________

Number of Children:

Spouse Name: ___________________

Phone: ________________________

| Today's Date | Age | Date of Birth | Sex: M F | Social Security Number | ☐ Married ☐ Single |
|---|---|---|---|---|---|
| / / | | / / | | - - | ☐ Divorced ☐ Widowed |

In Care of: ________________________________ Relation: ______________Phone: _______________
(Parent or financially responsible person)

Patient Employer's Name:_____________________________________

Address: ____________________________________________________

City: ______________________________ State: _______ Zip: ________

Phone: ___________________ Occupation: ________________________

EMPLOYED
☐ Full Time ☐ Part Time
☐ Retired ☐ Not Employed

STUDENT
☐ Full Time ☐ Part Time

**Referred By:**_____________________________________________________

If you were not referred to us, how did you hear about Maximized Health Chiropractic? _________________________
______________________________________________________________________________________

**Pregnancy Release**

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period ________________ .

_____________________________________________
Signature Date

**Please provide Primary Care Physician's information:**

Doctor's Name: ______________________________________________________

Office/ Clinic Name: ______________________________________________________

Address: ______________________________________________________

Clinic Phone Number: ______________________________________________________

**If referred by a Specialist or Injury Attorney please provide their information as well:**

Name: ______________________________________________________

Office/ Clinic Name: ______________________________________________________

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**PLEASE FILL IN THE APPROPRIATE SPACES.** (All information you give is confidential.)

MAJOR COMPLAINT: ____________________________________________

How long have you had this condition? ______________________ Date of Onset: _________________________________

Have you had this symptom or condition before? ☐ Yes ☐ No If yes, when? ____________________________________

Are your symptoms accident related? ☐ No ☐ Auto accident ☐ Work accident If yes, when? ________________________

Previous Chiropractic care? ☐ No ☐ Yes Chiropractor's Name: _______________________________________________

What was the reason for your initial visit? ________________________________________________________________

What spinal maintenance programs were you given to follow to maximize the future stability of your spine?
____________________________________________________________________________________________

Did you follow it? ☐ Yes ☐ No If not, why? ______________________________________________________________

Why are you changing Chiropractors? _____________________________________________________________________

What surgeries have you had? _____________________________________________________________________________

List drugs that you now take (prescription and non-prescription). ______________________________________________
____________________________________________________________________________________________

Name other doctors you have seen for this condition: _______________________________________________________

What are you currently doing to actively overcome this condition and/or maintain your health?
____________________________________________________________________________________________
____________________________________________________________________________________________

**Please indicate if you have had any of these symptoms in the last 12 months:**

| | | |
|---|---|---|
| ☐ Fractured bones | ☐ Neck Pain or Stiffness R L | ☐ Headaches: ☐ Tension ☐ Migraine |
| ☐ Auto Accidents<br>______ 0-1 yrs ago<br>______ 1-5 yrs ago<br>______5 or more | ☐ Numbness, Tingling, Pain in Arms, Hands, Fingers R L | ☐ Dizziness |
| ☐ Other Accidents, falls<br>Describe_____________ | ☐ Shoulder Pain R L | ☐ Ringing in Ears R L |
| ☐ Arthritis | ☐ Jaw Pain or Clicking (TMJ) R L | ☐ Hearing Loss R L Both |
| ☐ Diabetes | ☐ Difficulty in Excessive Standing, Sitting, Riding, Bending, Lifting, Twisting: ________________ | ☐ Blurred or Double Vision |
| ☐ Convulsions, Epilepsy | ☐ Numbness, Tingling, Pain in Buttocks, Legs, Feet, Toes R L | ☐ Chest Pain |
| ☐ Skin Problems | ☐ Foot Trouble R L | ☐ Asthma |
| ☐ Cancer | ☐ Upper Back Pain or Stiffness | ☐ Heart Problems |
| ☐ Frequent Colds, Flu | ☐ Mid Back Pain or Stiffness | ☐ Stroke |
| ☐ Depressed | ☐ Lower Back Pain or Stiffness | ☐ High Blood Pressure |
| ☐ Irritable | ☐ Pain with Cough or Sneeze | ☐ Low Blood Pressure |
| ☐ Anemia | ☐ Hip Pain R L | ☐ Varicose Veins |
| ☐ Allergy, Sinus | ☐ Bedwetting | ☐ Liver Problems |
| ☐ Under Stress | ☐ Ear Infections | ☐ Gall Bladder Problems |
| ☐ Eating Disorders | ☐ ADD / ADHD | ☐ Digestive Problems |
| ☐ Trouble Sleeping | | ☐ Ulcers |
| ☐ Trouble Concentrating | | ☐ Hemorrhoids |
| ☐ Learning Disability | | ☐ Prostate Problems |
| ☐ Mood Changes | | ☐ Impotence |
| | | ☐ Kidney Trouble |
| | | ☐ Menstrual Problems (PMS) |
| | | ☐ Pregnant (now) |
| | | ☐ Fertility Problems |
| | | ☐ AIDS, HIV |

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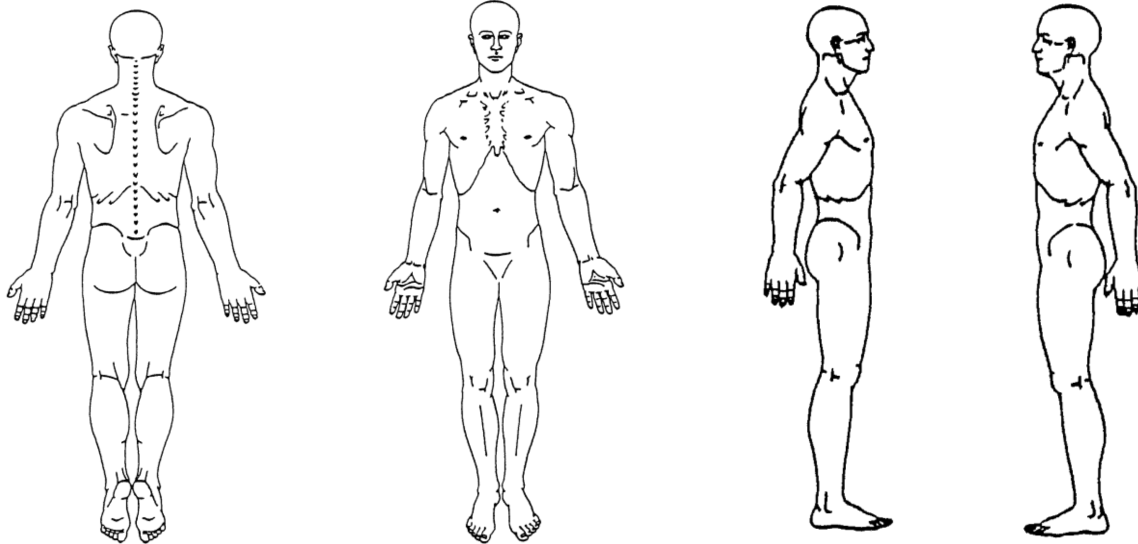
**On a Scale from 1 to 10 identify your area, current level and type of pain.**

Low…moderate…intense…emergency
1 2 3 4 5 6 7 8 9 10

A = Ache | B=Burning | N=Numbness
P = Pins & Needles | S = Stabbing | O = Other

Please Circle the Specific Area & Note Pain Level and Type



1. Which pain or condition identified is the ***worst***? ____________________________________

2. How ***long*** has it bothered you? ______________________________________________

3. Please describe what makes your condition or symptoms ***worse*** ________________________

   ______________________________________________________________________________

4. Please describe what makes your condition or symptoms ***better*** ________________________

   ______________________________________________________________________________

**PLEASE CIRCLE ONE:**

5. Spinal problems can cause painful symptoms. Is your pain ***sharp*** or ***dull***?

6. Spinal problems can cause symptoms that may be ***constant*** or ***occasional***.

7. Are your symptoms worse in the ***A.M.*** or ***P.M.***?

8. Do your pains/symptoms ***radiate*** into an extremity or ***stay in one area***?