New Patient History

Name _________________________________ Age ________

How did you find us? □ Chiropractor □ Therapist □ Friend/relative □ Internet
□ Doctor referral ____________________ □ Other __________________________

1. My current pain developed: □ Gradually □ Suddenly Date of onset ___/___/_____
   □ Motor vehicle accident Attorney: ______________________________
   □ Work injury: Date of injury ____/____/_____

2. Please make a mark on the line below to show your average pain level over the past week.
   No Pain _____________________ Worst pain Imaginable

Please use the following key to shade in the distribution of your pain on the figures:
Numbness ............ Pins and Needles 00000000 Pain /////////////

3. My pain is best described as (check all that apply):
   □ Dull □ Sharp □ Throbbing □ Constant □ Intermittent
   □ Aching □ Stabbing □ Shooting □ Burning □ Tingling
   □ Electrical

4. My pain is worse with (check all that apply):
   □ Bending forward □ Bending backward
   □ Sitting □ Standing □ Walking □ Laying down
   □ Looking up □ Looking down □ Turning left □ Turning right
   □ Cough/ sneeze □ Lifting □ Pushing / pulling
5. My pain is better with:  
- Laying down  
- Sitting  
- Standing  
- Therapy  
- Changing positions  
- Pain meds  
- Ice  
- Heat  
- Nothing

6. Have you experienced new bowel or bladder leakage/accidents recently?  
- Yes  
- No

7. Have you had any of the following tests for the current problem in the last 2 years?  
- X-rays  
- CT scan  
- MRI  
- EMG  
- Bone scan  
- Diagnostic Spinal Injections (e.g. epidural, facet/sacroiliac joint block, discogram)

8. Have you tried the following treatments for my pain (Circle those that helped):  
- Physical Therapy  
- Chiropractic  
- Acupuncture  
- Massage  
- Spinal Injections  
- Home/gym exercises  
- Surgery  
- Traction

9. Have tried the following medications for my pain (Circle those that helped, X out those that didn’t):  
- Anti-inflammatories (Ibuprofen, Aleve, Naproxen, Mobic, Celebrex, Diclofenac, Steroids)  
- Muscle relaxants (Soma, Flexeril, Carbamazepime, Zanaflex, Skelaxin, Robaxin, Methocarbamol)  
- Anti seizure drugs (Neurontin, Gabapentin, Lyrica)  
- Anti-depressants (Paxil, Zoloft, Nortriptyline, Amitriptyline)  
- Narcotics (Lortab, Hydrocodone, Oxycodone, Oxycontin, Ultram, Vicodin, Percocet, Methadone)

10. Medication Allergies:  
- None  
- Iodine  
- Contrast dye  
- Steroids  
- Local Anesthetics  
- Latex  
- Other: ________________________________

Allergic Reaction that occurred: ________________________________

11. Are you currently taking any blood thinning/anticoagulation medications?  
- YES  
- NO (Coumadin, Warfarin, Pradaxa, Plavix, Aggrenox, Aspirin, Flax seed, Fish Oil etc.)

12. Medications:  
- ____________________________________________
- ____________________________________________
- ____________________________________________
- ____________________________________________

13. Medical History:  
Please check the following medical problems you have now, or have had:  
- Heart problems  
- Thyroid problems  
- Easy bleeding  
- Osteoarthritis  
- Asthma  
- Epilepsy  
- Colon disease  
- Ulcers  
- Diabetes  
- Migraines  
- Vascular problems  
- Kidney problems  
- Stroke  
- Depression  
- Hepatitis/HIV  
- Bladder problem  
- Anxiety  
- Osteoporosis  
- Fibromyalgia  
- Lung Disease  
- Anemia  
- High blood pressure  
- Rheumatoid arthritis  
- Cancer  
- Other: ________________________________

Have you had previous back or neck problems?  
- Yes  
- No

Have your received care from a mental health professional?  
- Yes  
- No  
- Still seeing: ________________________________

Have you ever had an infection with MRSA?  
- Yes  
- No

14. Surgical History:  
Spine surgery?  
- None  
- Neck/Cervical  
- Mid-back/ Thoracic Spine  
- Low back/lumbar  
Orthopedic surgery?  
- None  
- Shoulder  
- Elbow  
- Wrist  
- Hand  
- Hip  
- Knee  
- Ankle  
- Foot  
Heart surgery or lung surgery?  
- No  
- Yes
Cardiac or peripheral stents?  
- No  
- Yes
15. **Family History**: Please check those illnesses that your family members have had

<table>
<thead>
<tr>
<th>Illness</th>
<th>Father</th>
<th>Mother</th>
<th>Siblings</th>
<th>Grandparents</th>
<th>Father</th>
<th>Mother</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Diabetes</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Neurologic Problems</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Cancer</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Arthritis</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

Father: [ ] Living [ ] Deceased (Age) ______  Mother: [ ] Living [ ] Deceased (Age) ______

16. **Social History**:

Do you now, or did you ever smoke? [ ] No  [ ] Yes  Packs per day? ______  Quit? ________

Do you drink alcohol? [ ] No  [ ] Yes  Daily [ ] Rarely

Do you now, or have you ever had a drug or alcohol problem? [ ] No  [ ] Yes

Please explain: ____________________________

Marital Status: [ ] Single  [ ] Married  [ ] Divorced  [ ] Widowed

17. **Vocational History**:

[ ] Employed Full Time  [ ] Employed Part time  [ ] Retired

[ ] Regular Duty  [ ] Light Duty  [ ] Disability (reason)________

Employer: ____________________________

Job Description: __________________________

Years at current job: ________  Date last worked: __________

Rate your current job satisfaction: [ ] Very Satisfied  [ ] Satisfied  [ ] Indifferent  [ ] Dissatisfied

Have you ever been on disability? [ ] No  [ ] Yes: ____________________________

How physically demanding is your job? Check one.

[ ] Very heavy (lifting > 100 pounds)  [ ] Heavy (lifting > 60 pounds)  [ ] Moderate (lifting > 30 pounds)

[ ] Light (lifting > 10 pounds)  [ ] White collar (no lifting)

18. **Review of Systems**:

Please check any of the symptoms you have had during the past year.

[ ] Fever  [ ] Chills  [ ] Unintentional weight loss of >10 #

[ ] Rashes  [ ] Skin infections  [ ] Itching of skin

[ ] Cataracts  [ ] Glaucoma  [ ] Double vision  [ ] Loss of vision

[ ] Ear infections  [ ] Mouth sores  [ ] Sore throat  [ ] Nasal congestion

[ ] Chest pain  [ ] Leg swelling  [ ] Irregular heart beat

[ ] Short of breath  [ ] Cough  [ ] Wheezing

[ ] Nausea  [ ] Vomiting  [ ] Abdominal pain

[ ] Blood in urine  [ ] Painful urination  [ ] Difficulty urinating

[ ] Dizziness  [ ] Seizures  [ ] Ringing in ears  [ ] Memory loss

[ ] Face numbness  [ ] Arm numbness  [ ] Leg numbness  [ ] Sudden weakness

[ ] Joint pain  [ ] Muscle pain  [ ] Difficulty walking

[ ] Depression  [ ] Anxiety  [ ] Hallucinations

[ ] High blood sugar  [ ] Thyroid disorder  [ ] Anemia

The information I have provided in this document is true and accurate to the best of my knowledge.

__________________________  ___________
Patient Signature         Date