

Arbor Vitae Chiropractic Clinic

NEW PATIENT INFORMATION

Welcome to our office! Please complete all questions below.

Name: (Full) _____ Nickname: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Social Security Number: _____

Birth Date: ____/____/____

Gender: Male Female

Marital Status: Single Married Widowed Divorced Legally Separated

e-mail Address: _____ Can we contact you by e-mail? _____

Employer: _____ Occupation: _____

Work Phone: _____ Fax/Work E-Mail _____

Spouse's Name: _____ Spouse's Birth Date: ____/____/____

Spouse's Employer: _____ Spouse's SSN: _____

Children's names and ages: _____

Who may we thank for referring you? _____

Do you have health Insurance? Yes No Insurance Co: _____

Deductible _____ Copay? _____ Who is the guarantor? _____

Method of payment for first visit: Cash Check Credit Card

Have you had previous Chiropractic Care? Yes No How long has it been since your last x-ray? _____

If yes, Doctor's Name: _____ Last Visit Date: _____

Is your pain the result of an: Auto Accident? No Yes _____ Work Injury? No Yes _____

Are you currently involved in any legal action involving this injury? No Yes What? _____

Are you taking prescription medications now? Yes No Over the counter? Yes No

List: _____

Please list any Vitamins, Minerals, Herbs, or Nutritional Products that you are currently taking:

For Women: Last Menstrual Period: _____ Are you pregnant? _____ Due? _____

The above information is true to the best of my knowledge.

Patient or Guardian Signature: _____ Date: _____

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CURRENT HEALTH CONDITION

Main Complaint(s) _____

How long have you had it? _____ Have you had it before? Yes No When _____

Rate Pain on a scale of: (1-mild to 10 severe) 1 2 3 4 5 6 7 8 9 10

Describe the Pain: Dull Sharp Throbbing Burning Deep Aching
 Tingling Stabbing Cramping Numbness Radiating

Constant Comes & Goes How often? _____

Does the Pain Radiate? No Yes Where? _____

Is the pain worse in the: Morning Afternoon Night No Difference

Activities Painful to Perform: Sitting Walking Bending Lying Down

Other: _____

Does it interfere with: Work Sleep Daily Routine Recreation _____

Other Doctors Seen for this condition: _____ When: _____

Recommendations or Treatment: _____

Additional health concerns/complaints in order of seriousness. Rate pain on scale of 1-10

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Anyone in your family with similar problems? _____ If yes, who? _____

Past Health History

Major Surgery/Operations: Dates: _____

Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery Broken bones

Hysterectomy Ear Tubes Child Birth Other: _____ In or out Pt. _____

Major Accidents of Falls: _____ When: _____ Treatment: _____

Hospitalizations (other than above): _____ When: _____ Treatment: _____

Habits	Heavy	Moderate	Light	None	Date of Last:	Within 2 years
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chiropractic Adjustment	<input type="checkbox"/>
Coffee/Tea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spinal Examination	<input type="checkbox"/>
Pop/Soda	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Exam	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Immunization	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood Test	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest x-ray	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies:	<input type="checkbox"/>
Pain Meds					Allergy to what?	

Physical Stress levels (1-mild to 10 severe) 1 2 3 4 5 6 7 8 9 10 Main Stressor: _____

Emotional Stress levels (1-mild to 10 severe) 1 2 3 4 5 6 7 8 9 10 Main Stressor: _____

Patient Signature: _____ Date: _____