NYGREN CHIROPRACTIC & ACUPUNCTURE

NEW PATIENT FORM

PERSONAL INFORMATION:

Name_____ DOB: _____ Age: _____ Sex: M F
Address_____City_____State_____Zip_____
Cell _____ Home Phone _____ Work Phone _____
Email:_____Referred By:_____
Occupation:_____Work Duties:_____
Exercise routine?_____
Other recreational activities/hobbies?_____
Marital Status: S M D W Name of Spouse_____Number of children_____
Emergency Contact: Name_____Relationship_____Phone (_____)_____-_____
Current Health Care Providers: Medical Doctor: _____Last seen for:_____
Chiropractor: _____ Last seen for:_____
Massage Therapist: _____ Last seen for:_____
Acupuncturist/Other:_____ Last seen for: _____

PRESENT CONDITION:

Is this a ___ Wellness Visit or is there a ___ Specific Concern?
Primary complaint for visit today:_____
This began: Date_____ How?(Include history with details)_____
_____
Describe the pain: __ Sharp __Dull __Ache __Pinch __Throb __Shooting __Burning __Tingle __Numb __Random __Constant ___On & Off ___Other: _____ Radiate/travel to other body parts? _____
Is this an auto accident or work related injury? Yes_____ No_____ Current Litigation? Yes_____ No_____
Previous tests or treatments for this problem:_____
_____
Rate your pain: 1(least) to 10 (most severe)___ This problem occurs?___Hourly ___Daily ___Weekly ___Monthly
List anything that makes it worse: _____
_____Time of day it's worse: _____
List anything that makes it better :_____
_____Time of day it's better:_____
Is your condition interfering with: __Work __Sleep __Driving __Exercise ___Other:_____
What are the most important activities you want to regain?_____
Where do you rate your overall health now? Sick- 1 2 3 4 5 6 7 8 9 10 -Healthy
I would like the following treatment(s) for this complaint:
___Chiropractic ___Acupuncture ___Supplement Program ___ Cold Laser ___Open to all

CASE HISTORY:

Past accidents, falls, or injuries?_____
_____
Surgeries and hospitalizations with dates:_____
Current prescription medications and what they are for:_____
_____
Current vitamins/herbs and what they are for:_____
_____
Family history of the same condition you have? Y N Family history of cancer, diabetes or heart illness? Y N
Please list:_____
Females: Last menses: _____ Pregnant? Y N Trying for pregnancy? Y N

Please check areas of stress that apply to your life, either in the past (P) as well as current (C).

P	C	Physical Stress
		Birth Trauma
		Slips/Falls
		Car Accidents
		Sports Injuries
		Physical Abuse
		Work Injuries
		Repetitive Movements
		Poor Posture
		Sitting on your wallet
		Sleep on Stomach
		Extensive Computer Work
		Heavy Purse/Backpack
		Driving many hours
		Continuous sitting/standing
		Bone Fractures
		Surgery

P	C	Emotional Stress
		Relationships
		Work
		Children
		Money/bills
		Homework
		Exams
		High Stress
		Fast Paced Life
		Hold in Feelings
		Quick Tempered
		Verbal Abuse
		Perfectionist
		Procrastinator
		Sickness/loss of loved one
		Self Esteem
		Other

P	C	Chemical Stress
		Work Environment
		Smoker/second hand
		Poor diet
		Caffeine—amount?
		Excessive Sugar
		Processed Foods
		Artificial Sweeteners
		Soda
		Antibiotics
		Prescription Meds
		Over the counter meds
		Recreational Drugs
		Energy Drinks
		Fast Food
		Microwaved Food
		Other

What symptoms has your body been experiencing? P = Past C= Current

P	C	
		Acid Reflux
		Allergies
		Asthma/COPD
		Bladder Problems
		Cancer
		Depression
		Diabetes
		Diarrhea/Constipation
		Dizziness/Vertigo
		Epilepsy
		Fatigue/Fibro
		Fertility Issues
		Gallbladder

P	C	
		Gout
		Headaches
		Heart Condition
		Hepatitis
		High Blood Pressure
		High Cholesterol
		HIV
		Insomnia
		Joint Pains
		Kidney Problems
		Menopause Symptoms
		Menstrual Problems
		Night Sweats

P	C	
		Pacemaker
		Prostate Problems
		Skin Conditions
		Sleep Apnea
		Stomach Problems
		Stroke
		Thyroid Problems
		Tremors
		Vaccine Reaction
		Varicose Veins (Severe)
		Weight gain (unexplained)

Patient Name: _____ Signature_____ Date: _____

Parent or Guardian Signature if patient is under 18_____ Date: _____