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:_____
Chiropractor: _____ Last seen:_____
Massage Therapist: _____ Last seen:_____
Acupuncturist/Other:_____ Last seen: _____

PRESENT CONDITION:

Chief Complaint:_____

This problem began: ☐ Gradually ☐ Suddenly Approx. Date: _____ Describe how: _____

_____

Treatments/tests run for this complaint & results:_____

_____

Auto accident or work related injury? Y N Litigation? Y N Pain Level: 1 (least) to 10 (severe) ____

This problem is: ☐ constant ☐ comes & goes ☐ chronic ☐ severe ☐ intense ☐ mild ☐ nagging

Describe your condition: ☐ Sharp ☐ Dull ☐ Throbs ☐ Swells ☐ Cramps ☐ Numb ☐ Stiff

☐ Aches ☐ Shooting ☐ Burns ☐ Tingles ☐ Other_____

This problem occurs: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other_____

Activities that make it Worse circle W, make it Better circle B, make No Change circle NC:

Sitting: W B NC Standing: W B NC Walking: W B NC Bending: W B NC

Lying down: W B NC Work: W B NC Sleep: W B NC Daily routine: W B NC

Recreation/Exercise: W B NC Driving: W B NC Dressing: W B NC House Chores: W B NC

Yard Work: W B NC Other: _____

What are the most important activities you want to regain?_____

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 Signature: _____ Date: _____

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