

Alternative Healthcare Center

8735 Dunwoody Place

Atlanta, GA 30350

(770) 992-4222

Chiropractic New Patient Form

PATIENT #: _____

DATE: _____

NAME: _____

CELL #: (____) _____ HOME #: (____) _____

E-MAIL ADDRESS: _____ REFERRED BY: _____

ADDRESS: _____ CITY: _____ STATE: ____

ZIP: _____

DATE OF BIRTH: __/__/__

MARITAL STATUS: S M D W

CHILDREN __ M __ F

EMPLOYER: _____ OCCUPATION: _____

SPOUSE'S NAME: _____ SPOUSE EMPLOYED BY: _____

SPOUSE'S OCCUPATION: _____

HISTORY AND COMPLAINTS

AREA(S) OF PAIN: _____

HOW LONG HAVE YOU HAD THIS PROBLEM: _____

HOW OFTEN: _____

AT ITS WORST ARE YOU CAPABLE OF NORMAL ACTIVITY? YES __ NO __

HAVE YOU SEEN ANOTHER DOCTOR FOR THIS PROBLEM? YES __ NO __ IF YES, WHO?:

IS THIS WORK RELATED? YES __ NO __ (IF YES, PLEASE LET US KNOW)

IS THIS AN INJURY RELATED TO AN AUTOMOBILE ACCIDENT? YES __ NO __

IF YES, WERE YOU THE ONLY OCCUPANT IN THE CAR? YES __ NO __

GIVE DETAILS:

HAVE YOU HAD ANY SURGERIES IN THE LAST 5 YEARS? YES__ NO__

LIST SURGERIES:

HAVE YOU EVER SEEN A CHIROPRACTOR? YES__ NO__

IF YES, WHEN WAS YOUR LAST TREATMENT? _____

DR. NAME AND ADDRESS: _____

PLEASE LIST ALL OF THE MEDICATIONS YOU ARE TAKING:

Confidential Patient History

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not believe your condition will respond satisfactorily, we will not accept your case.

Please circle the appropriate letter for any of the following symptoms you have or have had previously. We want all of the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O – Occasionally					
F – Frequently					
C – Constantly					
General					
O F C	Allergies	O F C	Feet	O F C	Hay Fever
O F C	Chills	O F C	Tailbone	O F C	Hoarseness
O F C	Convulsions	Gastro-Intestinal		O F C	Nasal Obstruction
O F C	Dizziness	O F C	Belching or Gas	O F C	Near Sightedness
O F C	Fainting	O F C	Colitis	O F C	Nosebleeds
O F C	Fatigue	O F C	Colon Trouble	O F C	Sinus Infection
O F C	Fever	O F C	Constipation	O F C	Sore Throat
O F C	Headache	O F C	Diarrhea	O F C	Tonsillitis
O F C	Loss of Sleep	O F C	Difficult Digestion	Cardiovascular	
O F C	Loss of Weight	O F C	Abdominal Distension	O F C	Hardening of Arteries
O F C	Nervousness/Depression	O F C	Excessive Hunger	O F C	High Blood Pressure
O F C	Neuralgia	O F C	Gallbladder Trouble	O F C	Low Blood Pressure
O F C	Numbness	O F C	Hemorrhoids	O F C	Pain Over Heart
O F C	Stress	O F C	Intestinal Worms	O F C	Poor Circulation
O F C	Tremors	O F C	Jaundice	O F C	Rapid Heartbeat
Muscle and Joint		O F C	Liver Trouble	O F C	Slow Heartbeat
O F C	Arthritis	O F C	Nausea	O F C	Swelling of Ankles
O F C	Bursitis	O F C	Stomach Pain	Respiratory	
O F C	Foot Trouble	O F C	Poor Appetite	O F C	Chest Pain
O F C	Hernia	O F C	Vomiting	O F C	Chronic Cough
O F C	Low Back Pain	O F C	Vomiting Blood	O F C	Difficult Breathing
O F C	Lumbago	Eyes, Ears, Nose & Throat		O F C	Spitting up Blood
O F C	Neck Pain or Stiffness	O F C	Asthma	O F C	Spitting up Phlegm
O F C	Pain between Shoulders	O F C	Colds	O F C	Wheezing
O F C	Poor Posture	O F C	Crossed Eyes	Skin	
O F C	Sciatica	O F C	Deafness	O F C	Boils
O F C	Spinal Curvature	O F C	Dental Decay	O F C	Bruise Easily
O F C	Swollen Joints	O F C	Earache	O F C	Dryness
Pain or Numbness in:		O F C	Ear Discharge	O F C	Hives or Allergy
O F C	Shoulders	O F C	Ear Noises	O F C	Itching
O F C	Arms	O F C	Enlarged Glands	O F C	Rash
O F C	Elbows	O F C	Enlarged Thyroid	O F C	Varicose Veins
O F C	Hands	O F C	Eye Pain	Ctnd. on next page	
O F C	Hips	O F C	Falling Vision		
O F C	Legs	O F C	Far Sightedness		
O F C	Knees	O F C	Gum Trouble		

O – Occasionally	
F – Frequently	
C – Constantly	
Genito-Urinary	
<input type="radio"/> O <input type="radio"/> F <input type="radio"/> C	Bed Wetting
<input type="radio"/> O <input type="radio"/> F <input type="radio"/> C	Blood in Urine
<input type="radio"/> O <input type="radio"/> F <input type="radio"/> C	Frequent Urination
<input type="radio"/> O <input type="radio"/> F <input type="radio"/> C	Inability to Control Kidneys
<input type="radio"/> O <input type="radio"/> F <input type="radio"/> C	Kidney Infection or Stones
<input type="radio"/> O <input type="radio"/> F <input type="radio"/> C	Painful Urination
<input type="radio"/> O <input type="radio"/> F <input type="radio"/> C	Prostate Problem
<input type="radio"/> O <input type="radio"/> F <input type="radio"/> C	Pus in Urine
For Women Only	
<input type="radio"/> O <input type="radio"/> F <input type="radio"/> C	Congested Breasts
<input type="radio"/> O <input type="radio"/> F <input type="radio"/> C	Cramps or Backache
<input type="radio"/> O <input type="radio"/> F <input type="radio"/> C	Excessive Menstrual Flow
<input type="radio"/> O <input type="radio"/> F <input type="radio"/> C	Hot Flashes
<input type="radio"/> O <input type="radio"/> F <input type="radio"/> C	Irregular Cycle
<input type="radio"/> O <input type="radio"/> F <input type="radio"/> C	Menopausal Symptoms
<input type="radio"/> O <input type="radio"/> F <input type="radio"/> C	Painful Menstruation
<input type="radio"/> O <input type="radio"/> F <input type="radio"/> C	Vaginal Discharge
<input type="radio"/> Yes <input type="radio"/> No	Are You Pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD

<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	Cold Sores	<input type="checkbox"/>	Goiter	<input type="checkbox"/>	Miscarriage	<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Gout	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Appendicitis	<input type="checkbox"/>	Diphtheria	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Arteriosclerosis	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	Influenza	<input type="checkbox"/>	Pleurisy	<input type="checkbox"/>	Typhoid Fever
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Lumbago	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Malaria	<input type="checkbox"/>	Polio	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	Chorea	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	Measles	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Whooping Cough

Have you had previous chiropractic care? ____ If yes, date of last care: _____

Do you have Health and Accident Insurance? ____ If yes, with what company? _____

Is this an Industrial Accident Case? _____

PLEASE PRINT

What is your major complaint?

Other complaints

How long have you had this condition? _____

Have you had this or a similar condition in the past? _____

What activities aggravate your condition?

Is this condition getting progressively worse? (circle one) Yes No Constant Comes and Goes

Is this condition interfering with your (circle all that apply) Work Sleep Daily Routine Other:

How long has it been since you felt really good? _____

List previous diagnoses and treatments you have received for present condition

What do you believe is wrong with you?

List surgical operations and years

Drugs you now take (circle all that apply) Nerve pills Pain killers Muscle relaxers "Pep" pills
Tranquilizers Birth control pills Other: _____

Dental Visits (circle one) Every 6 months Yearly Toothache or emergency

Complete dentures

Age of Mattress _____ Circle one: Comfortable Uncomfortable

Do you use a bed board? _____

Are you wearing (circle as appropriate) Heel lifts Sole lifts Inner soles Arch supports

Have you been in an auto accident? (circle one) Past year Past 5 years Over 5 years ago Never

Describe _____

Have you ever had any mental or emotional disorders? (circle one) Yes No

When? _____

Have others in your family had such disorders? (circle one) Yes No

When? _____

FAMILY HEALTH INFORMATION

Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health.

Name	Relation	Past and Present Health Problems

HAVE YOU EVER:	YES	NO	DESCRIBE BRIEFLY
Been knocked unconscious?			
Used a cane, crutch, or other support?			
Been treated for a spine or nerve disorder?			
Had a fractured bone?			
Been hospitalized for anything other than surgery?			
DO YOU:			
Now take vitamins or minerals?			
Think you may need vitamins or minerals?			
Have an allergy to any drug?			

Date of Last:	Less than 6 months ago	6-18 months ago	Over 18 months ago	Never
Spinal Examination				
Physical Examination				
Blood Test				
Chest X-ray				
Spinal X-ray				
Dental X-ray				
Urine Test				

HABIT	Heavy	Moderate	Light	Never
Alcohol				
Coffee				
Tobacco				
Drugs				
Exercise				
Sleep				
Appetite				

LIST BELOW ALL OF THE CONDITIONS YOU HAVE BEEN TREATED FOR IN THE PAST

IN CASE OF EMERGENCY, (relative or close friend not living in your home)

NAME: _____ PHONE: _____

ADDRESS: _____



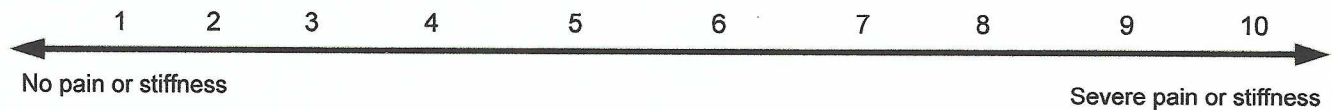
This information will be used to provide a clearer picture of your health. There are no correct answers, so honestly rate each question. Please read and mark the score for each question on the scale.

Print your Name: _____

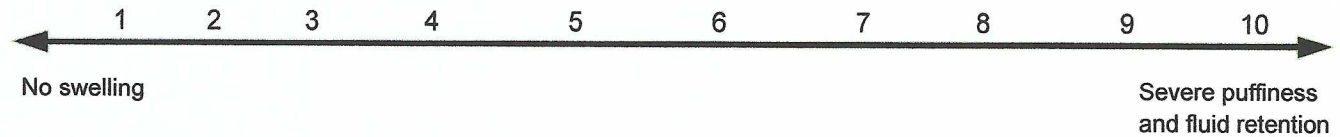
Date: _____

Circle One: **Pre-Program** or **Post-Program**

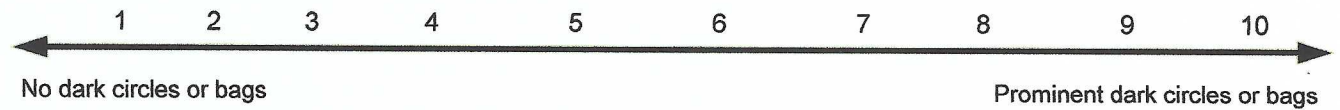
Joint Pain or Stiffness



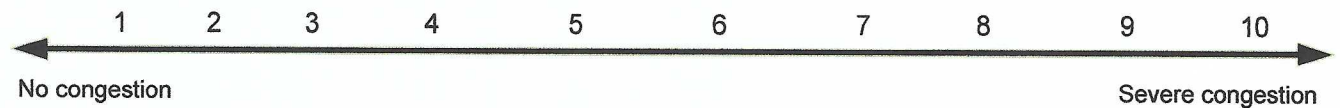
Water Retention or Puffiness



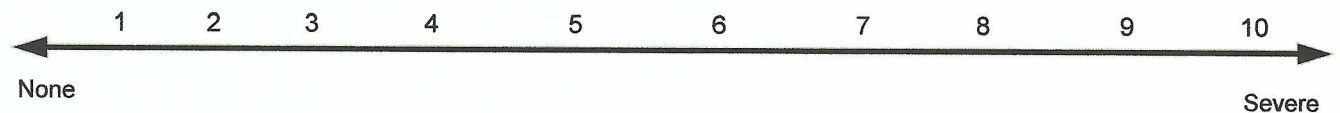
Dark Circles or Bags under the Eyes



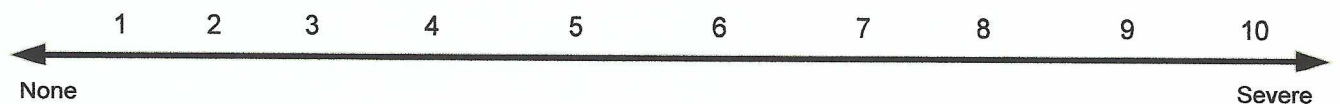
Stuffy Nose, Head or Sinus Congestion



Bloating, Belching or Lower Bowel Gas



Dry or Itchy Skin



Post Question: Overall, what did you think of this 10-Day Program? _____

For Clinical Use Only:

Weight: _____ Height: _____ Frame: _____ Age: _____
Res: _____ Reac: _____ % BF: _____ PA: _____ BMI: _____