Alternative Healthcare Center

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Atlanta, GA 30350

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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	
O F C	Bed Wetting
O F C	Blood in Urine
O F C	Frequent Urination
O F C	Inability to Control Kidneys
O F C	Kidney Infection or Stones
O F C	Painful Urination
O F C	Prostate Problem
O F C	Pus in Urine
For Women Only	
O F C	Congested Breasts
O F C	Cramps or Backache
O F C	Excessive Menstrual Flow
O F C	Hot Flashes
O F C	Irregular Cycle
O F C	Menopausal Symptoms
O F C	Painful Menstruation
O F C	Vaginal Discharge
Yes **No**	Are You Pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD

	Alcoholism		Cold Sores		Goiter		Miscarriage		Scarlet Fever
	Anemia		Diabetes		Gout		Multiple Sclerosis		Stroke
	Appendicitis		Diphtheria		Heart Disease		Mumps		Tuberculosis
	Arteriosclerosis		Eczema		Influenza		Pleurisy		Typhoid Fever
	Arthritis		Emphysema		Lumbago		Pneumonia		Ulcers
	Cancer		Epilepsy		Malaria		Polio		Venereal Disease
	Chorea		Fever Blisters		Measles		Rheumatic Fever		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: _____

10 DAY PROGRAM
INFLAMMATION

Pre & Post Survey

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

1 2 3 4 5 6 7 8 9 10

No pain or stiffness — Severe pain or stiffness

Water Retention or Puffiness

1 2 3 4 5 6 7 8 9 10

No swelling — Severe puffiness and fluid retention

Dark Circles or Bags under the Eyes

1 2 3 4 5 6 7 8 9 10

No dark circles or bags — Prominent dark circles or bags

Stuffy Nose, Head or Sinus Congestion

1 2 3 4 5 6 7 8 9 10

No congestion — Severe congestion

Bloating, Belching or Lower Bowel Gas

1 2 3 4 5 6 7 8 9 10

None — Severe

Dry or Itchy Skin

1 2 3 4 5 6 7 8 9 10

None — Severe

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: _____