

New Patient History

Oliver Chiropractic

ABOUT YOU

Patient's Name:		Today's Date:	
Patient's Date of Birth:		Social Security Number: - -	
What you prefer to be called:	Age:	Sex:	Drivers License #
Mailing Address	City	State	Zip
Home phone #:	Work phone #:		
Other phone #:	E-mail address		
Who may we thank for referring you?			
Employer:	How long?		
Employer's Address:			
Occupation:	Status: Married / Divorced / Single / Widowed		
Spouse's Name:	Spouse's Occupation:		
Do you have children? Yes / No How many?			

IN EVENT OF EMERGENCY

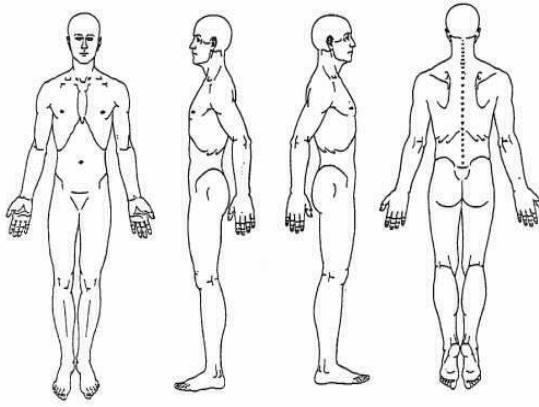
Who should we contact?	Relation:
Home Phone #:	Work Phone #:

CURRENT PROBLEM

Please check all of the following that describes your current problem:

- | | | |
|---|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Migraines | <input type="checkbox"/> Neck Pain / Stiffness |
| <input type="checkbox"/> Shoulder Pain / Stiffness | <input type="checkbox"/> Wrist / Hand Pain or Stiffness | <input type="checkbox"/> Upper Back Pain or Stiffness |
| <input type="checkbox"/> Mid Back Pain or Stiffness | <input type="checkbox"/> Low Back Pain or Stiffness | <input type="checkbox"/> Hip Pain or Stiffness |
| <input type="checkbox"/> Knee Pain or Stiffness | <input type="checkbox"/> Ankle/Foot Pain or Stiffness | <input type="checkbox"/> Pain w/ coughing |
| <input type="checkbox"/> Pain shooting down leg(s) | <input type="checkbox"/> Pain w/ sneezing | <input type="checkbox"/> Painful Joints |
| <input type="checkbox"/> Pain shooting down arms(s) | <input type="checkbox"/> Numbness | |

What is the most painful or troublesome condition causing you to consult our office today?



Date problem started or flare-up of pain began:

Is your current problem related to?

- Chronic Condition
- Old Injury / Injuries
- Recent Auto Accident
- Recent Work Injury

How did the problem begin or start?

- Accident / Trauma
- Gradual onset
- Sudden onset
- After Home activities

Please draw X where you have pain or other symptoms.

Please Circle the level of pain you have right now:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

How often are your symptoms present?

- 0 - 25%
- 26- 50%
- 51- 75%
- 76-100%

What activities are painful?

- Movement of painful or injured area
- Bending and Stooping
- Sitting
- Walking
- Standing
- Lifting
- Pushing & Pulling
- Overhead work
- Desk Work

What make your symptoms feel better?

- Nothing
- Over the counter medication
- Prescription medication
- Rest
- Stretching
- Activity / Exercise
- Therapy

What home therapy have you tried?

- Nothing
- Cold
- Stretching
- Ointments / Rubs
- Heat
- Rest
- Activity / Exercise
- Heat Patches

What describes the nature of your complaint(s)?

- Sharp
- Dull Ache
- Shooting
- Tingling
- Numbness
- Burning
- Weakness

How are your symptoms changing?

- Getting Better
- Not Changing
- Getting Worse

When are your symptoms worse?

- Morning
- Afternoon
- Evening
- After activities
- After rest & inactivity
- Other

How is your sleep?

- Normal
- Mild Fragmented
- Very Fragmented
- Poor - little sleep

Can you perform your daily activities?

- Yes
- No

CONFIDENTIAL HEALTH HISTORY

Have you had recent spinal x-rays? No Yes
 Have you had a MRI or CT scan performed in the past? No Yes

Dates Taken

What areas were taken?

Have you had prior chiropractic care? No Yes
 Have you had prior physical therapy No Yes

Have you ever had surgery or been hospitalized? No Yes Please List Surgeries:

Dates

Procedures

Are you taking any of the following medications?

Pain killers Anti-inflammatory Muscle Relaxers
 Stimulants Nerve Pills Other

Please check all of the following that apply to you: None Apply

No Yes Condition

- History of Recent Infection
- Recent Fever
- HIV/AIDS
- Diabetes
- Corticosteroid Use
- Birth Control Pills
- High Blood Pressure
- Stroke (date) _____
- Dizziness/Fainting
- Numbness in Groin/Buttocks
- Urinary Retention
- Aortic Aneurysm
- Cancer/Tumor
- Recent Trauma

No Yes Condition

- Prostate Problems
- Frequent Urination
- Pregnancy, # of births _____
- Abnormal Weight Gain Loss
- Epilepsy/Seizures
- Visual Disturbances
- History of Low/Mid Back Pain
- History of Neck Pain
- Arthritis
- History of Alcohol Use
- History of Tobacco Use
- Surgeries/Medications: _____
- Osteoporosis

Family History: Cancer Diabetes High Blood Pressure Cardiovascular Problems/Stroke
For women only: Are you pregnant? No Yes _____ (Initial)

I certify that the above information is complete and accurate.

 Patient / Guardian Signature

 Date