## New Patient History Form

Name					
City	State	Zip	Home pl	ı#	
Cell# (For confirming appt. schedule):		Carrier: 🗆	'erizon □ATT V	Vireless 🗆 T-Mobile	Other
E-mail Address (For confirming appointment so	chedule) :				
SSN	Date of birth		Age	Height	Weight
Male $\square$ Female $\square$ Single $\square$ Married $\square$ Divo	orced $\square$ $\#$ of children $\_$	Name	of spouse (or p	parent)	
Employer		Address			
City State	Zip	Wk phn		Occupation	l
What is the name of your family physician? _			What city (	are they located in?	
Have you ever had Chiropractic care before? _	If yes, doctor	name:		Date of	last visit
If you are experiencing any pain (neck pain, mid b	ack pain, low back pain, e	tc.), health proble	ms, symptoms,	and/or complaints, pl	ease list in order of severity
1		For how long?			
2		For how long?			
3		For how long?			
4 Has this problem been getting \( \subseteq \text{worse or } \subseteq \) working? If yes, please describe what a Are there any other activities, incidents, or ev	staying the same? Cactivities at work may b	urrently or in the	e past have yo	u ever experienced	any of these complaints while
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The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing). In other words, we would like to know how much your health condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES.

O means no disability at all, and a score of 10 means that all of the activities in which you would normally be involved have been totally disrupted or prevented by your health condition (pain and/or symptoms you may be experiencing).

	<u>0</u> Completely able to function	1 2	3	4	5	6	7	8	9 unab	<u>10</u> Totally le to function
,	ME RESPONSIBILITI doing dishes, erro				,	•		•	med aroun	d the house
2. RECREATION	l: hobbies, sports,	and other si	milar leisure ti	me activiti	ies.					
	IVITY: activities wh certs, dining out, (		•	ith friends	and acquai	ntances of	ther than	family me	embers inc	luding parties,
4. OCCUPATIO or voluntee	N: activities that a r worker.	re a part of (	or directly rela	ted to one	's job includ	ing nonpa	ying jobs	as well, s	such as tha	t of a homemaker 
5. SELF CARE: (	activities which inv	olve person	al maintenance	e and inde	pendent dai	ly living (1	aking a sl	nower, dr	iving, getti	ing dressed, etc.)
6. LIFE SUPPOI	RT ACTIVITY: basic	life supporti	ng behaviors s	uch as eat	ing, sleepin	g, and bre	athing.			
	eriencing any heal For example, dull,			, when sta		g, walking		ram belo	w. Also de	scribe the type and frequenc
Method of payı	ment for today's cl	harges:	□ CASH		□ CHECK	[	□ CREDIT	CARD		

NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE TYPE OF CARE AND LENGTH OF CARE. IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

- 1. All first visit charges are payable when services are rendered.
- 2. The fee paid for x-rays is for analysis only. We are required to maintain your original x-rays. Films may be loaned to another health provider with your prior authorization only.

Patient's Signature	Date	8
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