NEW PATIENT/CONDITION FORM
PERFECT HEALTH CHIROPRACTIC

Name: ______________________________ Date: ______________

Address: ________________ City: ____________ State: ______ Zip: ______

Age: ______ Sex: ______ Birth Date: ______________ Marital Status: M S W D

Phone: __________ Social Security: ______________ Spouse's Name: __________

Occupation: ________________ Employer: ______________________

Work Phone: __________ Work Address: ______________________

Referred By: ______________________________ Number of Children: ______

E-Mail Address: ____

What is/are your major complaints? ______________________________

Is this a condition due to an? Auto Accident ____ Work Injury ____

(Check One) Unknown Illness ____ Illness ____ Other Injury ____

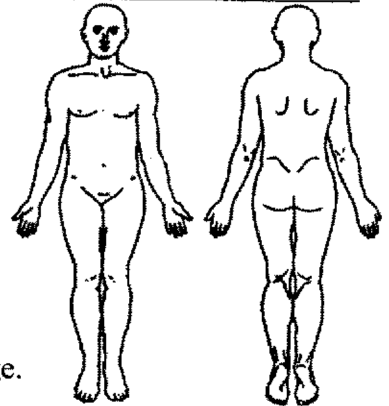
Are the symptoms: Improving ____ Getting Worse ____ Same ____

Come and Go ____ When did the symptoms appear? __________

Which phrases best describe *changes* in your symptoms during the day?

____ It is worse in the morning. ____ It is worse in the afternoon.

____ It is worse at night. ____ It changes with the weather. ____ It doesn't change.



What describes the frequency? ____ Constant (76-100% of the time) ____Frequent (51-75%)

____ Intermittent (26-50% of the time) ____ Occasional (0-25%)

What helps relieve your condition? Ice Heat Medication Nothing Helps Other __________

What activities are limited by your symptoms?

☐ Bending	☐ Driving	☐ Pulling	☐ Sleeping	☐ Urination
☐ Bowel Movement	☐ Getting Up	☐ Pushing	☐ Sneezing	☐ Walking
☐ Coughing	☐ Lifting	☐ Reading	☐ Standing	☐ Working
☐ Daily Routine	☐ Lying Down	☐ Sitting	☐ Turning My Head	☐ Other ________

Have you had these symptoms before? (Y / N) If so, when? ______________

Have you seen anyone else for this condition? _____ Dr.'s Name: ______________

Date Consulted: ______________ Diagnosis: ______________

Date of Last:		Habits:		Have you ever:	
	Physical Exam		Alcohol		Been knocked unconscious?
	Spinal X-ray		Coffee		Used a crutch or other support?
	MRI		Tobacco		Been treated for a spine or nerve disorder?
	Dental X-ray		Drugs		Had a fractured bone?
	CT Scan		Coke or Pepsi		Been hospitalized for other than surgery?
	Other scans or x-rays		Other		Ever had a surgery?

Please list any drugs now taken, allergies, and past surgeries: ______________

____

Check the Following Conditions You Have or Had!

Circle items that are common to other family members.

Have	Had		Have	Had		Have	Had	
		Alcoholism			Emphysema			Multiple Sclerosis
		Anemia			Goiter			Polio
		Appendicitis			Gout			Rheumatic Fever
		Cancer			Heart Disease			Stroke
		Diabetes			Miscarriage			Tuberculosis
		Eczema			Foot Problems			Ulcers

Please check the appropriate box for any of the following symptoms which you NOW have OR have HAD.

This is a confidential report.

Often	Rarely		Often	Rarely		Often	Rarely		Often	Rarely	
GENERAL					Knees			Sinus Infections	GENITO-URINARY		
		Allergy (list below)			Feet	CARDIO-VASCULAR					Bed-Wetting
		Convulsions	GASTRO-INTESTINAL					Hardening of Arteries			Blood in Urine
		Dizziness or Fainting			Colon Trouble			High Blood Pressure			Frequent Urination
		Headaches			Constipation			Low Blood Pressure			Incontinence
		Neuralgia			Diarrhea			Pain Over Heart			Kidney Infection/Stones
		Numbness			Difficult Digestion			Poor Circulation			Painful Urination
MUSCLE & JOINT					Abdomen Distended			Rapid Heart Beat			Prostate Trouble
		Arthritis			Gall Bladder Trouble			Slow Heart Beat			Pus in Urine
		Bursitis			Hemorrhoids			Swelling of Ankles	FOR WOMEN ONLY		
		Foot Trouble			Liver Trouble	RESPIRATORY					Congested Breasts
		Low Back Pain			Pain Over Stomach			Chest Pain			Cramps or Backache
		Neck Pain/Stiffness	EYES, EARS & NOSE					Chronic Cough			Excessive Menstrual Flow
		Between Shoulders			Asthma			Difficult Breathing			Hot Flashes
		Sciatica			Colds			Spitting Up Blood			Irregular Cycle
		Swollen Joints, Pain			Deafness			Spitting Up Phlegm			Lumps in Breasts
		Shoulders			Earache			Wheezing			Menopausal Symptoms
		Arms			Ear Discharge	SKIN					Painful Memstruation
		Elbows			Ear Noises			Bruise Easily			Pregnant (Y / N)
		Hands			Eye Pain			Dryness	Last Period:		
		Hips			Nasal Obstruction			Skin Eruptions (Rash)			
		Legs			Nose Bleeds			Varicose Veins			

Have you ever been in an auto accident? (   ) Yes (   ) No When? ______________________

Have you been treated by a physician for any health condition in the past year? (   ) Yes (   ) No

By whom? ____________________ Address: ______________________________

Describe condition: ____

Are you allergic to any medication? (   ) Yes (   ) No What kind? ____________________

After reading and filling out the case history, your signature will verify that all the information you have given us is accurate and that you have read the case history questions entirely. Your signature below also signifies that you are consenting to Chiropractic care that has been recommended at this clinic and that you are aware of the risks involved with such care.

Patient Signature: ______________________________ Date: ______________

Signature of Legal Guardian (if applicable): ______________________________