New Patient Information Questionnaire

We are committed to serving our community in a professional clinical environment and to empower patients to actively participate in their healthcare. Amazing Touch Chiropractic recognizes and respects the self-aware, self-directed, self-maintaining, self-healing, and self-improving nature of life and living beings.

Today's Date: _____ Whom may we thank for referring you to our office? _____

Patient Info

Name:_____

E-Mail:_____

Address:_____

_____

Phone #: _____

Birthday:_____ Age: _____

Occupation:_____

Sex: M ☐ F ☐

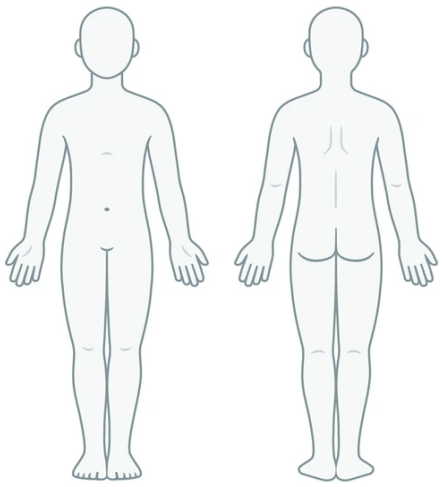
☐ Single ☐ Married ☐ Separated ☐ Divorced

Spouse's Name:_____

Emergency Contact Name & Number:

_____

Please mark where you are experiencing symptoms



History of Complaint

Please identify the condition(s) that brought you in:

Primary:_____

When did your symptoms appear?

_____

Is this condition getting progressively worse?

_____

Rate the severity of your pain on a scale of 1 (least pain) to 10 (most pain):_____

Description:

☐ Sharp ☐ Dull ☐ Throbbing
☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps
☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain?

_____

Is it constant or does it come and go?

_____

Does it interfere with:

☐ Work ☐ Sleep ☐ Daily Routine
☐ Recreation

Activities or movements that are difficult:

☐ Sitting ☐ Standing ☐ Walking
☐ Bending ☐ Lying Down

Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery
☐ Chiropractic ☐ Physical therapy ☐ None ☐ Other:_____

Name and phone number of doctor(s) you have seen:_____

Have you had a physical exam or X-Ray/MRI for this issue? (if yes please write date) _____

Please Circle "**Yes**" if you have experienced this issue or "**No**" if you have not.

AIDS/HIV	Yes	No	Emphysema	Yes	No	Miscarriage	Yes	No	Suicide Attempt	Yes	No
Alcoholism	Yes	No	Epilepsy	Yes	No	Mononucleosis	Yes	No	Thyroid Issues	Yes	No
Allergy Shots	Yes	No	Fractures	Yes	No	Multiple Sclerosis	Yes	No	Tonsilitis	Yes	No
Anemia	Yes	No	Glaucoma	Yes	No	Mumps	Yes	No	Tuberculosis	Yes	No
Anorexia	Yes	No	Goiter	Yes	No	Osteoporosis	Yes	No	Tumors	Yes	No
Appendicitis	Yes	No	Gonorrhea	Yes	No	Pacemaker	Yes	No	Typhoid Fever	Yes	No
Arthritis	Yes	No	Gout	Yes	No	Parkinson's	Yes	No	Ulcers	Yes	No
Asthma	Yes	No	Heart Disease	Yes	No	Pinched Nerve	Yes	No	Vaginal Infection	Yes	No
Bleeding Disorder	Yes	No	Hepatitis	Yes	No	Pneumonia	Yes	No	STDs	Yes	No
Breast Lump	Yes	No	Hernia	Yes	No	Polio	Yes	No	Whooping Cough	Yes	No
Bronchitis	Yes	No	Herniated Disc	Yes	No	Prostate Issue	Yes	No	Other:_____		
Bulimia	Yes	No	Herpes	Yes	No	Prosthesis	Yes	No	_____		
Cancer	Yes	No	High Cholesterol	Yes	No	Psychiatric Care	Yes	No	_____		
Cataracts	Yes	No	Kidney Disease	Yes	No	Rheumatoid	Yes	No	_____		
Chicken Pox	Yes	No	Liver Disease	Yes	No	Rheumatic Fever	Yes	No	_____		
Diabetes Type 1	Yes	No	Measles	Yes	No	Scarlet fever	Yes	No	_____		
Diabetes Type 2	Yes	No	Migraines	Yes	No	Stroke	Yes	No	_____		

Additional Info

Exercise
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

Work Activity
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

Habits
- ☐ Smoking Packs/Day_____
- ☐ Alcohol Drinks/Week_____
- ☐ Caffeine Drinks Cups/Day_____
- ☐ High Stress Reason_____

Are you pregnant? ☐ Yes ☐ No Due Date_____

Injuries/Surgeries you have had	**Description**	**Date**
Falls:		
Head Injuries:		
Broken Bones:		
Dislocations:		
Surgeries:		
Previous Car Accidents:		

Medications/Allergies (please list all below)

_____

_____

Pharmacy Name:_____Pharmacy Phone #_____