



CHIROPRACTIC NEW PATIENT INFORMATION FORM

Optimal Living Institute

Page 1 of 2

Please print clearly:

Name _____ Date _____

Address _____ Apt.# _____

City _____ State _____ Zip _____

Mailing Address (if different) _____

Home Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____ Work Phone (_____) _____ - _____

E-mail address: _____

REFERRED BY: _____

Date of Birth _____ Age _____ Sex: M / F

Occupation _____ Employer _____

Marital Status: Married Single Widowed Divorced Name of Spouse: _____

Names and Ages of Children: _____

Emergency Contact: _____

CHIEF COMPLAINT

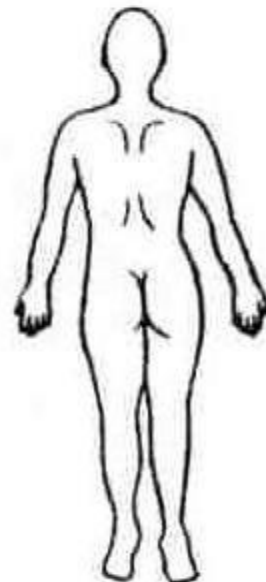
Mark your area of discomfort with the described sensation. Use the appropriate symbols.

Please rate the pain on a scale of 0 to 10 next to each area, with 0 being no pain and 10 being intolerable pain.

XXX Burning (BU)
---- Numbness (NU)

(((Aching pain (AC)
::: Sharp pain (SH)

000 Pins & Needles





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Page 2 of 2

PLEASE DESCRIBE YOUR PAIN OR CONDITION

Symptoms developed from: Auto Accident Work Related Injury Other _____

When did they begin? _____

How did it occur? _____

What makes your condition better? _____ What makes your condition worse? _____

Does the pain interfere with your sleep? **Y N** Does the pain get worse at night? **Y N**

Does icing help? **Y N** Does heat help? **Y N** Do you wear a heel lift? **Y N**

Does your pain interfere with work or living habits? **Y N** If so, how? _____

QUESTIONS FOR HEADACHE

Do you experience:

Nausea or Vomiting? **Y N**

Visual Disturbances? **Y N**

Pain or cracking in jaw? **Y N**

Abnormal blood pressure? **Y N**

QUESTIONS FOR NECK

Do you experience:

Difficulty turning your head? **Y N**

Pain or pressure behind eyes? **Y N**

Numbness in hands/fingers? **Y N**

QUESTIONS FOR LOW BACK

Do you experience:

Numbness/tingling in feet or legs? **Y N**

Pain down your legs? **Y N**

Changes in bowel or bladder function? **Y N**

Are you currently suffering from any condition other than that for which you are consulting us? If yes, what? _____

PAST MEDICAL HISTORY

Have you ever seen a chiropractor before? **Y N** If so, for what condition? _____

Have you had this condition in the past? **Y N** If yes, when? _____

Have you previously seen a doctor for the condition you are consulting us about? **Y N** If yes, when? _____

Where were you treated? _____ By Whom? _____

Diagnosis they gave you? _____ Results? _____

Patient signature: _____ Date: _____