CHIROPRACTIC NEW PATIENT EVALUATION

Optimal Living Institute

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 ____

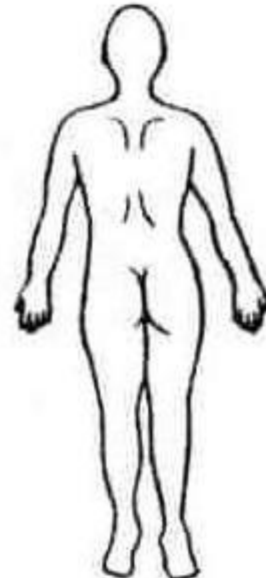
Marital Status: Married Single Widowed Divorced Name of Spouse: _________________________________

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.



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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	**QUESTIONS FOR NECK**	**QUESTIONS FOR LOW BACK**
Do you experience:	Do you experience:	Do you experience:
Nausea or Vomiting? **Y N**	Difficulty turning your head? **Y N**	Numbness/tingling in feet or legs? **Y N**
Visual Disturbances? **Y N**	Pain or pressure behind eyes? **Y N**	Pain down your legs? **Y N**
Pain or cracking in jaw? **Y N**	Numbness in hands/fingers? **Y N**	Changes in bowel or bladder function? **Y N**
Abnormal blood pressure? **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:** _________________________