

# AGEE CHIROPRACTIC & WELLNESS CENTER

## NEW PATIENT INFORMATION FORM

Please print clearly:

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Ht. \_\_\_\_\_ Wt. \_\_\_\_\_

Contact Information: (Please check best number to call)

- Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
- Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
- Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Best time to call: \_\_\_\_\_ May we leave a message? Yes \_\_\_ No \_\_\_

E-mail address: \_\_\_\_\_

In case of emergency notify: \_\_\_\_\_ Phone \_\_\_\_\_

Relationship: \_\_\_\_\_

### **Other information**

SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

Listed below are the persons, including all of all my medical doctors, who are involved in my care with whom you may share my protected health information regarding my treatment or payment issues:

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

Patient or Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

- Please check this box if you have placed more information on back

# AGEE CHIROPRACTIC & WELLNESS CENTER

## NEW PATIENT HISTORY FORM

PLEASE PRINT CLEARLY:

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Are you currently under the care of a physician or other health care professional? Yes No

(If yes, please give name and date of last visit): \_\_\_\_\_  
\_\_\_\_\_

Do you exercise on a regular basis? Yes \_\_\_\_\_ No \_\_\_\_\_

Please explain what kind of exercise you do \_\_\_\_\_  
\_\_\_\_\_ What type of  
dental work have you had in the past?

Have you had yeast infections? If so, when was the last one: \_\_\_\_\_

Do you crave sugar/sweets? Yes \_\_\_\_\_ No \_\_\_\_\_

How often do you have these cravings? \_\_\_\_\_

How would you rate your sleep? (Please circle one) Poor Fair Good Great

How is your energy/strength/stamina? (Please circle one) Poor Fair Good Great

Name of Spouse (if married): \_\_\_\_\_

Health of spouse: \_\_\_\_\_

Do you have children? Yes No Any health concerns?

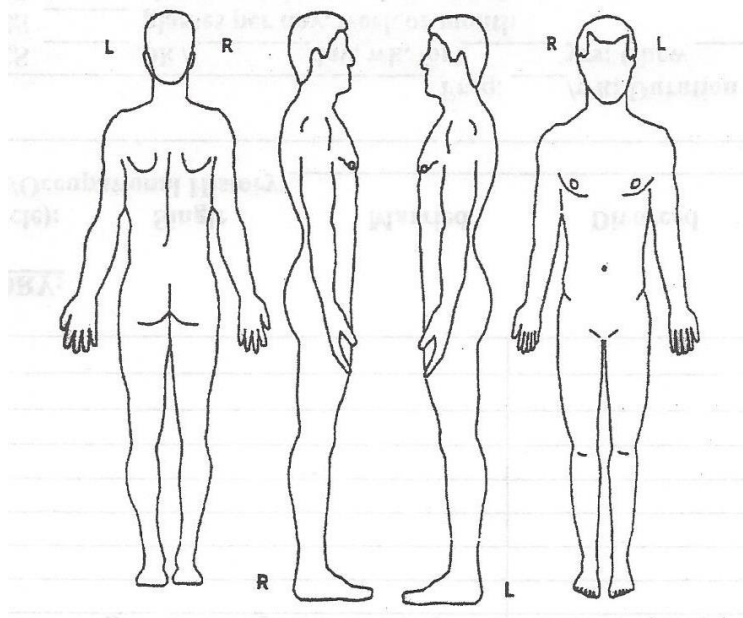
What can we do to make you happier?

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# AGEE CHIROPRACTIC & WELLNESS CENTER

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ PN: \_\_\_\_\_

INSTRUCTIONS: Please mark the areas on your body where you feel your PAIN. If the pain radiates, draw an arrow from where the pain starts to where it stops. Please extend the arrows as far as the pain travels.



## REVIEW OF SYSTEMS

Please mark and X beside any of the symptoms/conditions listed below that you CURRENTLY are experiencing.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Weakness                    | <input type="checkbox"/> Arthritis                     | <input type="checkbox"/> Heart Problems             |
| <input type="checkbox"/> Fatigue                     | <input type="checkbox"/> Bursitis                      | <input type="checkbox"/> High Blood Pressure        |
| <input type="checkbox"/> Fever                       | <input type="checkbox"/> Foot Trouble                  | <input type="checkbox"/> Heart Murmurs              |
| <input type="checkbox"/> Headaches                   | <input type="checkbox"/> Poor Posture                  | <input type="checkbox"/> Poor Circulation           |
| <input type="checkbox"/> Sleep Loss                  | <input type="checkbox"/> Chronic Cough                 | <input type="checkbox"/> Swelling of Ankles         |
| <input type="checkbox"/> Weight Loss                 | <input type="checkbox"/> Spinal Curvature              | <input type="checkbox"/> Chest Pain                 |
| <input type="checkbox"/> Nausea                      | <input type="checkbox"/> Frequent Colds                | <input type="checkbox"/> Depression/Nervousness     |
| <input type="checkbox"/> Wheezing                    | <input type="checkbox"/> Tingling/Numbness             | <input type="checkbox"/> Difficult Breathing        |
| <input type="checkbox"/> Hearing Loss                | <input type="checkbox"/> Constipation                  | <input type="checkbox"/> Diarrhea                   |
| <input type="checkbox"/> Bowel/Bladder Problems      | <input type="checkbox"/> Frequent Urination            | <input type="checkbox"/> Hemorrhoids                |
| <input type="checkbox"/> Earache                     | <input type="checkbox"/> Inability to Control Bladder  | <input type="checkbox"/> Kidney Infection or Stones |
| <input type="checkbox"/> Bloody Stool                | <input type="checkbox"/> Memory Problems               | <input type="checkbox"/> Loss of Appetite           |
| <input type="checkbox"/> Sinus/Hay Fever             | <input type="checkbox"/> Fainting                      | <input type="checkbox"/> Vomiting                   |
| <input type="checkbox"/> Heat/Cold Intolerance       | <input type="checkbox"/> Painful Menstruation          | <input type="checkbox"/> Loss of Interest or Energy |
| <input type="checkbox"/> Dizziness                   | <input type="checkbox"/> Joint Pain/Swelling/Stiffness | <input type="checkbox"/> Loss of Consciousness      |
| <input type="checkbox"/> Vision Problems             | <input type="checkbox"/> Excessive Hunger/Thirst       | <input type="checkbox"/> Asthma                     |
| <input type="checkbox"/> Glasses/Contact Lens        | <input type="checkbox"/> Palpitations                  | <input type="checkbox"/> Thyroid Problem            |
| <input type="checkbox"/> Sexual Dysfunction          | <input type="checkbox"/> Clumsiness                    | <input type="checkbox"/> Back and Neck Pain         |
| <input type="checkbox"/> Swallowing Difficulties     | <input type="checkbox"/> Muscle Pain/Cramps            | <input type="checkbox"/> Stress (Emotional)         |
| <input type="checkbox"/> Speech Problems/ Hoarseness | <input type="checkbox"/> Irritable                     | <input type="checkbox"/> Seizures or Convulsions    |
| <input type="checkbox"/> Excessive Sweating          | <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Easy Bruising or Bleeding  |

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PAST HISTORY

I. PAST MEDICAL HISTORY

Prior MAJOR

Illnesses: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Prior

Surgeries/Operations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Prior

Hospitalizations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current

Medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Allergies

(Drug/Food): \_\_\_\_\_

\_\_\_\_\_

Prior MAJOR Injuries (MVA, WC,

SLIP/FALL, BROKEN BONES): \_\_\_\_\_

\_\_\_\_\_

II. FAMILY HISTORY: \*Please tell us if there is a History of Cancer, Diabetes, Cardiac Problems, Stroke, Blood Pressure Problems, Headaches, Neck Pain, Back Pain or Surgeries in your FAMILY.

Family History	Living? Medical problems in any:	Deceased? Cause of death:
Mother	_____	_____ Date: _____
Father	_____	_____
Brother	_____	_____
Brother	_____	_____
Sister	_____	_____
Sister	_____	_____
Children	_____	_____
Children	_____	_____

III. SOCIAL HISTORY:

Marital Status (circle):

Single      Married

Divorced      Widowed

Current

Employment/Occupational

History:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Exercise: Type: \_\_\_\_\_ Fr

eq. \_\_\_\_/wk.; Duration

\_\_\_\_\_ Min./Hrs.; \_\_\_\_\_

Tobacco: No / Yes \_\_\_\_ pk. / \_\_\_\_ day, wk., for \_\_\_\_ yrs.

**Chew** \_\_\_\_ yrs.      **Pipe** \_\_\_\_ yrs.

Caffeine: No / Yes \_\_\_\_ glasses per day, week or month

Alcohol: No / Yes \_\_\_\_ glasses per day, week or month

Sleep Interrupted? No / Yes

\_\_\_\_\_ x's / night for

\_\_\_\_\_ mo., yrs.

Patient Signature: \_\_\_\_\_

\_\_\_\_\_

\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_