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

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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: _____

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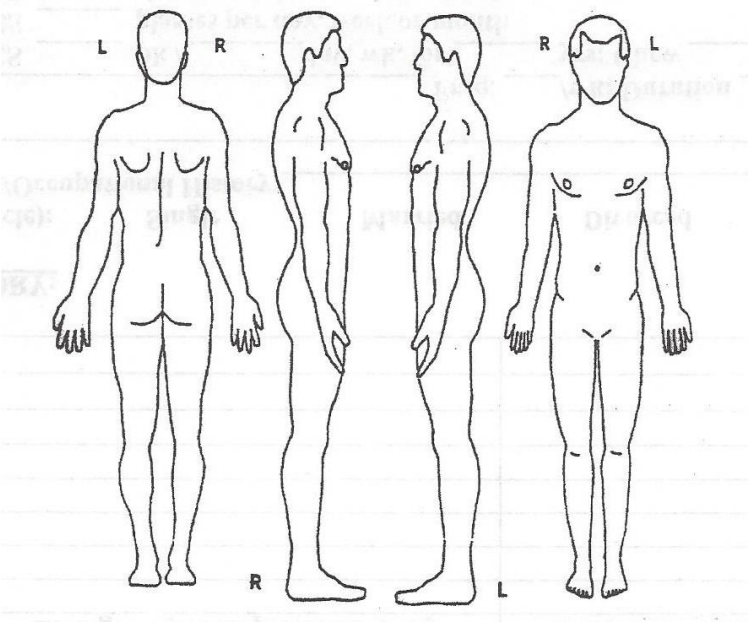
PATIENT NAME:_____ DATE:_____PN:_____

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.

_Weakness
_Fatigue
_Fever
_Headaches
_Sleep Loss
_Weight Loss
_Nausea
_Wheezing
_Hearing Loss
_Bowel/Bladder Problems
_Earache
_Bloody Stool
_Sinus/Hay Fever
_Heat/Cold Intolerance
_Dizziness
_Vision Problems
_Glasses/Contact Lens
_Sexual Dysfunction
_Swallowing Difficulties
_Speech Problems/ Hoarseness
_Excessive Sweating

_Arthritis
_Bursitis
_Foot Trouble
_Poor Posture
_Chronic Cough
_Spinal Curvature
_Frequent Colds
_Tingling/Numbness
_Constipation
_Frequent Urination
_Inability to Control Bladder
_Memory Problems
_Fainting
_Painful Menstruation
_Joint Pain/Swelling/Stiffness
_Excessive Hunger/Thirst
_Palpitations
_Clumsiness
_Muscle Pain/Cramps
_Irritable
_Diabetes

_Heart Problems
_High Blood Pressure
_Heart Murmurs
_Poor Circulation
_Swelling of Ankles
_Chest Pain
_Depression/Nervousness
_Difficult Breathing
_Diarrhea
_Hemorrhoids
_Kidney Infection or Stones
_Loss of Appetite
_Vomiting
_Loss of Interest or Energy
_Loss of Consciousness
_Asthma
_Thyroid Problem
_Back and Neck Pain
_Stress (Emotional)
_Seizures or Convulsions
_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		
Father		
Brother		
Brother		
Sister		
Sister		
Children		
Children		

III. SOCIAL HISTORY:

Marital Status (circle):
Single Married
Divorced Widowed

Current Employment/Occupational History:
_____
_____
_____
_____
_____
_____

Exercise: Type: _____Freq.____/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:
_____
_____Date:_____
_____