

New Patient Information

Please print clearly

Date: ____/____/____

Patient Name: _____ Sex: Male Female
Last First M.I.

Address: _____
Street City State Zip

Parent or Guardian (if patient is a minor): _____

Is patient employed? Yes No Full-time student Occupation: _____

Employer or School: _____ Marital Status: Married Single Other

Home Phone: (____) ____-____ Work Phone: (____) ____-____ ext. ____

E-mail: _____

Date of Birth: ____/____/____ SS#: ____-____-____

Primary Care Dr.: _____

How did you hear about our office? _____

EMERGENCY CONTACT (not living with patient): _____

Phone: (____) ____-____ Relationship: _____

Insurance Information:

Primary Insurance Co: _____

Group #: _____ Policy I.D./Claim #.: _____

Is patient the subscriber? Yes No **If no, then:**

Subscriber's Name: _____ Subscriber's Employer: _____

Relationship to Patient: _____ Subscriber Date of Birth: ____/____/____

In Order to Bill Your Insurance, We Must Have a Copy of Your Insurance Card.

Injury Information:

Condition is related to: Work Auto Home Sports Other None

Date of injury/onset of condition: ____/____/____

Body side: Right Left Both Body part affected: _____

Attorney or Claims Manager or Vocational Rehab Counselor:

Name: _____ Phone (____) ____-____

E-mail: _____ Fax (____) ____-____

Address: _____
Street City State Zip

For Office Therapist: _____ DC Number: _____

Use Only Dx Codes: _____

Integrated Center for Optimum Health, LLC

Integrated Center for Optimum Health, LLC
(Confidential)

Patient Name: _____ **Today's Date:** _____

Describe how/when your problem occurred: _____

Have you had a similar problem previously? Yes No

Specifics: _____

How would you describe your overall health?
 Poor Fair Good Excellent

What is your present: Height _____ Weight _____ lbs.

How would you describe your exercise level?
 None Moderate Daily Heavy

Are you able to continue your recreational or sporting activities? Yes No

Specifics: _____

Are you able to continue working? Yes No

If no, when did you last work? _____

Are the physical demands of your job? Light Moderate Heavy

During work what do you normally do? Sit Stand

What are your goals and expectations for chiropractic treatment? _____

Confidential Health History

Name _____ Date _____

Age _____ Birthdate _____ Date of Last Physical Examination _____

What is the reason for your visit? _____

Symptoms

Check (✓) conditions you currently have or have had in the past year.

General

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Numbness
- Sweats

Muscle/Joint/ Bone

Pain, weakness, numbness in:

- Arms Hips
- Back Legs
- Feet Neck
- Hands Shoulders

Genito-Urinary

- Blood in Urine
- Frequent urination
- Lack of bladder control
- Painful urination

Gastrointestinal

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

Cardiovascular

- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling ankles
- Varicose veins

Eye, Ear, Nose, Throat

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision – Flashes
- Vision – Halos

Skin

- Bruise easily
- Hives
- Itching
- Change in moles
- Rash
- Scars
- Sore that won't heal

MEN only

- Breast lump
- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other

WOMEN only

- Abnormal Pap smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Other

Date of last menstrual period: _____

Date of last Pap Smear _____

Have you had A mammogram? _____

Are you pregnant? _____

Number of children _____

Symptoms

Check (✓) conditions you currently have or have had in the past year.

- AIDS
- Alcoholism
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorders
- Breast Lump
- Bronchitis
- Bulimia
- Cancer
- Cataracts

- Chemical Dependency
- Chicken Pox
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heart Disease
- Hepatitis
- Hernia
- Herpes

- High Cholesterol
- HIV Positive
- Kidney Disease
- Live Disease
- Measles
- Migraine Headaches
- Miscarriage
- Mononucleosis
- Multiple Sclerosis
- Mumps
- Pacemaker
- Pneumonia
- Polio

- Prostate Problem
- Psychiatric Care
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Suicide Attempt
- Thyroid problem
- Tonsillitis
- Tuberculosis
- Typhoid Fever
- Ulcers
- Vaginal Infections
- Venereal Disease

Medications List medications that you are currently taking

Allergies

Pharmacy Name: _____ Phone: _____

Family History

Relation	Age	State of Health	Age at Death	Cause of Death	Check if your blood relatives had any of the following	
					✓ Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

***Hospitalizations**

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? Yes No

If yes, please give approximate dates: _____

Serious Illness/Injuries	Date	Outcome

Pregnancies***Health Habits******Occupational***

Year of Birth	Sex of Birth	Complications, if any	Check (✓) which substances you use and describe how much you use		Check (✓) if your work exposes you to the following:	
				Caffeine		Stress
				Tobacco		Heavy Lifting
				Drugs		Hazardous Substances
				Other		Other
						Occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor/therapist or any members of her/his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature

Date

Reviewed By

Date