



NEW PATIENT PROFILE

PERSONAL

Last Name _____ First Name _____ Date _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Alternate Phone _____ Email _____
 Social Security # _____ Driver's Lic # _____ State Where Issued _____
 Age _____ Birthdate _____ Sex _____ Married Single Widowed Divorced No of Children _____
 Occupation _____ Employer _____ Years Employed _____
 Employer's Address _____ City _____ State _____ Zip _____
 Spouse or Partner's Name _____ Occupation _____ Employer _____
 Person responsible for this account? _____ Referred by _____

CONDITION

What is your major complaint? _____
 Other complaints? _____
 How long have you had this condition? _____ Have you had this or similar conditions in the past? Yes No
 What activities aggravate your condition? _____
 Is this condition getting progressively worse? Yes No Unsure Constant Comes and goes
 Is this condition interfering with your: Work Sleep Daily routine Other
 How long has it been since you really felt good? _____
 List surgical operations: _____
 Are you taking any medications? Yes No If so, what kind? _____
 Are you taking any non-prescription drugs? Yes No If so, what kind? _____
 OTHER DOCTORS SEEN FOR THIS CONDITION: MD DC DO DDS
 Doctor's Name _____ Diagnosis _____
 Are X-rays available? Yes No Urinalysis? Yes No Blood Tests? Yes No Other
 Treatment: Medication _____ Physiotherapy _____
 Results _____ Length of time under care _____
 Were you off of work? Yes No If so, how long? _____ Have you returned to same job? Yes No

How often do you experience your symptoms?

- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (26-50% of the day)
- Intermittently (0-25% of the day)

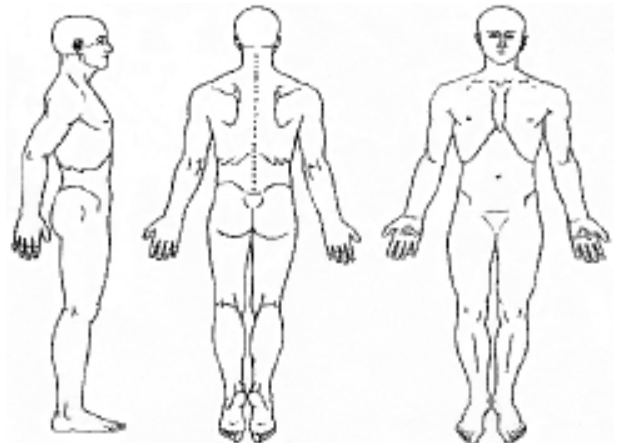
What describes the nature of your symptoms?

- Sharp Shooting Dull Ache Burning Numb Tingling

During the past 4 weeks, indicate the average intensity of your symptoms:

None Unbearable

1 2 3 4 5 6 7 8 9 10



Indicate above where you have pain or other symptoms

HEAD

- Headache
 - sinus (allergy)
 - entire head
 - back of head
 - forehead
 - temples
 - migraine
- Head feels heavy
- Lose of memory
- Light-headedness
- Fainting
- Light bothers eyes
- Blurred vision
- Double vision
- Loss of vision
- Loss of taste
- Loss of balance
- Dizziness
- Loss of hearing
- Pain in ears
- Ringing in ears
- Buzzing in ears

NECK

- Pain in neck
- Neck pain with movement
 - Forward
 - Backward
 - Turn to left
 - Turn to right
 - Bend to left
 - Bend to right
- Pinched nerve in neck
- Neck feels out of place
- Muscle spasms in neck
- Grinding sounds in neck
- Popping sounds in neck
- Arthritis in neck

SHOULDERS

- Pain in right shoulder joint
- Pain in left shoulder joint
- Pain across shoulders
- Bursitis (right)
- Bursitis (left)
- Arthritis (right)
- Arthritis (left)
- Can't raise arm:
 - above shoulder level
 - over head
- Tension in shoulders
- Pinched nerve in right shoulder
- Pinched nerve in left shoulder
- Muscle spasms in shoulders

ARMS & HANDS

- Pain in upper arms
- Pain in elbows
- Movement aggravated
- Tennis elbow
- Pain in forearms
- Pain in hands
- Pain in fingers
- Sensation of pins & needles in arms
- Sensation of pins & needles in fingers
- Numbness in right arm
- Numbness in left arm
- Numbness in fingers (right)
- Numbness in fingers (left)
- Fingers go to sleep
- Hands cold
- Swollen joints in fingers
- Sore joints in fingers
- Arthritis in fingers
- Loss of grip strength

MID-BACK

- Mid-back pain
- Location _____
- Pain between shoulder blades
- Sharp stabbing
- Dull ache
- Pain from front to back
- Muscle spasms
- Pain in kidney area

CHEST

- Chest pain
- Shortness of breath
- Pain around ribs
- Breast pain
- Dimpled or orange peel breast
- Irregular heartbeat

ABDOMEN

- Nervous stomach
- Foods you can't eat:

- Nausea
- Gas
- Constipation
- Diarrhea
- Hemorrhoids

LOW BACK

- Low back pain
 - Upper lumbar
 - Lower lumbar
 - Sacroiliac
- Low back pain is worse when:
 - working
 - lifting
 - stooping
 - standing
 - sitting
 - bending
 - coughing
 - lying down (sleeping)
 - walking
- Pain relieves when
- Slipped disk
- Low back feels out of place
- Muscle spasms
- Arthritis

HIPS, LEGS & FEET

- Pain in buttocks (right side)
- Pain in buttocks (left side)
- Pain down right leg
- Pain down left leg
- Knee pain:
 - inside
 - outside
- Leg cramps
- Cramps in right foot
- Cramps in left foot
- Pins & needles in right leg
- Pins & needles in left leg
- Numbness in right leg
- Numbness in left leg
- Numbness in right foot
- Numbness in left foot
- Numbness in toes (right foot)
- Numbness in toes (left foot)
- Feet feel cold
- Swollen ankle (right leg)
- Swollen ankle (left leg)

WOMEN ONLY

- Menstrual pain
 - Where?
- Cramping
- Irregularity
- Cycle _____ days
- Birth control
 - Type?
- Hysterectomy
- Genital cancer
- Discharge
- Menopause
- Tumors
- Abortions
- Are you or do you think you are pregnant?

MEN ONLY

- Urinary frequency
- Difficulty in starting
- Night urination
- Prostate pain/swelling

GENERAL

- Nervousness
- Irritable
- Depressed
- Fatigued
- Generally feel run-down
- Normal sleep (in hours) _____
- Loss of sleep (in hours/night) _____
- Loss of weight _____ lbs.
- Weight gain _____ lbs.
- Coffee (cups per day) _____
- Tea (cups per day) _____
- Cigarettes (packs per day) _____
- Other
- Diabetes
- Hypoglycemia

REMARKS

Please use the space below to share any additional symptoms, concerns or thoughts:

INSURANCE

Are you covered by Medicare? Yes No If so, Medicare # _____ State Insurance Aid? Yes No

Do you have any group, union or personal health and accident insurance? Yes No

Name of Insurance Company _____ Claim Number _____ Group Number _____

Address _____ Phone _____ Agent Name _____

Additional Insurance Company _____ Claim Number _____ Group Number _____

Address _____ Phone _____ Agent Name _____

Is your condition due to an accident? Yes No Is your condition due to an illness? Yes No Other

ACCIDENT

Did your accident occur while on the job? Yes No Were you involved in an auto accident? Yes No

Date _____ Time _____ Injury reported to employer? Yes No Supervisor _____

Description of accident: _____

Were you injured? Yes No If so, how? _____

Location of accident _____

Were you unconscious? Yes No Fractures? Yes No Cuts? Yes No Bruises? Yes No

Were you taken to a hospital? Yes No If so, which one? _____ Treatment _____

Confined to hospital for _____ days _____ hours Name of attending physician _____

Have you had any other personal injury or accident? Past year Past 5 years Over 5 years None

Describe this accident: _____

Do you have an attorney? Yes No If so, name _____

Address _____ Phone _____ Email _____

COMPLEMENTARY THERAPIES

Are you interested in learning more about Nutrition Weight Loss Body Detoxification

Are you interested in learning more about Massage Therapy Orthopaedic Ultra-Sound Therapy

AGREEMENT

I, the undersigned, clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient (print)

Patient signature

Date



AUTHORIZATION & RELEASE

SIGNATURE ON FILE

I, the undersigned, hereby authorize the following:

1. Use of this form on all insurance submissions;
2. Release of my medical and chiropractic information to my insurance company(ies);
3. My chiropractor to act as my agent in helping me obtain payment from my insurance company(ies);
4. Payment direct to my chiropractor.

In addition to the above, I permit a copy of this authorization to be used in place of the original and understand that I am responsible for payment of all bills relating to treatment administered by Active Chiro Center.

Patient (print)

Social Security No.

Patient signature

Date