KOCH CHIROPRACTIC CENTER

New Patient Form

TODAY'S DATE: _______________

CONTACT INFO AND MEDICAL HISTORY:

Full Name: ____ Nickname:_____________________ Birthdate: __________________

Address: ____ City: ______________________ State: ________ Zip: ________________

Best Contact number: _______________________ Secondary phone number: ____

Employer: __________________________________ Employer address: ____

Occupation: ________________________________ Work related activity: ____

Who is your primary care physician? _____________________________________ Date of last exam? __________________________

Any Problems Found: ____

Medications you are taking: ____

List any **surgical procedures**, and the year: ____

Past history and year of any significant **physical trauma** including fractures, auto accidents, or other injuries (please describe):

____

____

Family Health History and their relationship to you (ex: heart disease – mother)

____

Height: __________________ Weight: ______________________ Is your weight constant? ☐ YES ☐ NO

Do you exercise?	Do you use tobacco?	Do you drink alcohol?
☐ Never	☐ Never	☐ Never
☐ Occasionally	☐ Occasionally	☐ Occasionally
☐ Frequently	☐ Frequently	☐ Frequently

Check if you have ever suffered from:

☐ Asthma	☐ Digestive disorders	☐ Seizures
☐ Allergies	☐ High blood pressure or	☐ Slurred speech or partial paralysis
☐ Breathing problems	☐ Other vascular diseases	☐ Cancer ; type:_________________________________
☐ Bladder or bowel problems	☐ Arthritis	☐ Other ______________________________________

Have you had previous chiropractic care? ☐ YES ☐ NO

If YES, where: ____When_______________________

Have you had previous imaging studies done in the last five years? (MRI/ X-ray) ☐ YES ☐ NO

If YES, where: ____ When: ______________________

PLEASE FILL OUT OTHER SIDE

REASON FOR CONSULTATION:

What is your chief complaint? ____

Additional complaints: ____

How long have you had this problem? ______________________ Is it getting worse? ☐ YES ☐ NO

Was the onset ☐ GRADUAL or ☐ SUDDEN? If sudden, what were you doing at the time? ______________

____

Have you seen anyone else for this condition(s), if so who, what was done, & results? ______________

____

____

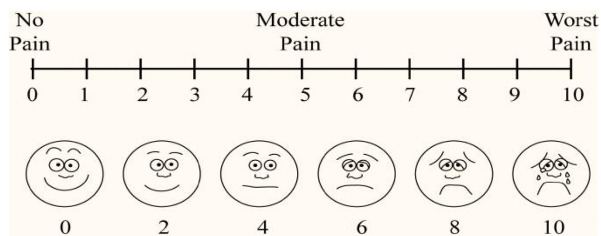
Do you have any pain or numbness radiating into your arms or legs? ☐ YES ☐ NO Where? ______________

Is your condition ☐ CONSTANT or does it ☐ COME AND GO ?

What seems to make it worse? ____

What seems to make it better? ____

Circle the **level of pain** you are feeling now.



Check if your condition is interfering with:

☐ Work ☐ Bending ☐Other ______________

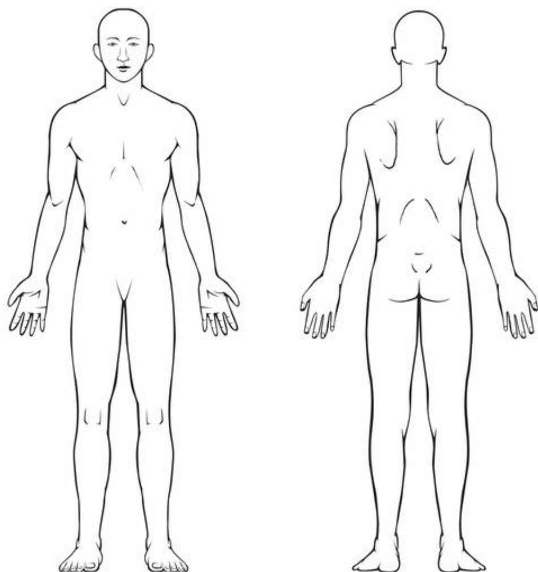
☐ Sleep ☐ Driving

☐ Lifting ☐ Sexual Relations

Was there anything you were able to do before, that **you no longer are able to** because of your current condition?

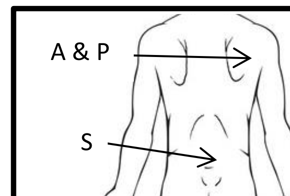
____

Please use the letters listed to describe your location of pain and sensations:



A – Ache
N – Numbness
B – Burning
P – Pins & Needles
S – Stabbing
R – Radiating
O – Other ______________

Example:



Patient Signature: ______________________________ Date: ______________