KOCH CHIROPRACTIC CENTER

New Patient Form

TODAY'S DATE: _____

CONTACT INFO AND MEDICAL HISTORY:

Full Name: _____ Nickname:_____ Birthdate/Age: _____ /____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email Address: _____

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?

- ☐ Never
- ☐ Occasionally
- ☐ Frequently

Do you use tobacco?

- ☐ Never
- ☐ Occasionally
- ☐ Frequently

Do you drink alcohol?

- ☐ Never
- ☐ Occasionally
- ☐ Frequently

Check if you have ever suffered from:

- ☐ Asthma /breathing problems
- ☐ Allergies
- ☐ Headaches/Migraines
- ☐ Bladder or bowl problems
- ☐ Digestive disorders
- ☐ High blood pressure or
- ☐ Other vascular diseases
- ☐ Arthritis
- ☐ Seizures
- ☐ Slurred speech or partial paralysis
- ☐ Cancer ; type:_____
- ☐ 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: _____

How did you hear about our office? _____

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? _____

_____

_____

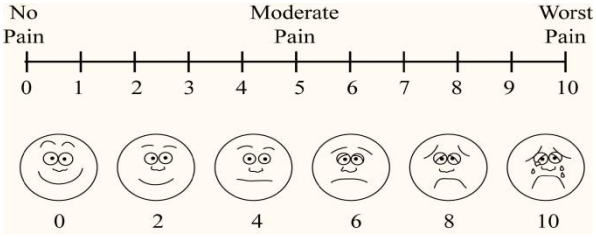
Do you have any pain or numbness radiating into your arms or legs? ☐ YES ☐ NO Where? _____

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 _____

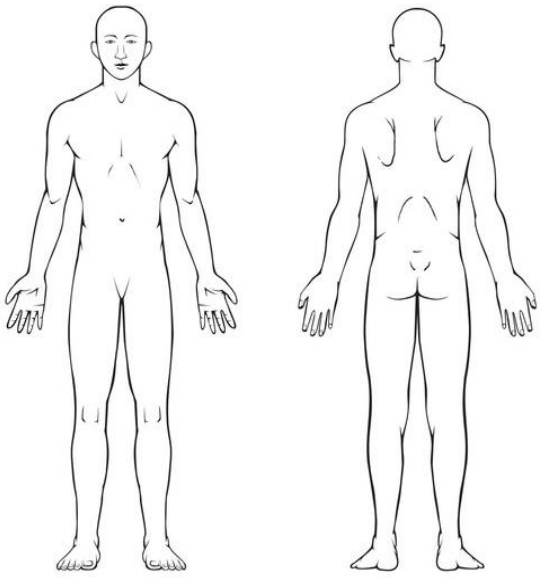
☐ Sleep ☐ Driving

☐ Lifting ☐ Sexual Relations

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

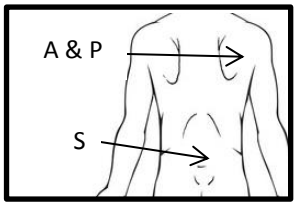
_____

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: _____