New Patient History Form

Please fill out the following form in as much detail as possible.

Name: ______________________________ Date: ______________________

Email Address: ______________________________ Occupation: ______________________

Marital Status: ____S ____M ____D ____W Spouses Name: ______________________

# of children: __________ Names: ____

What is your chief complaint?____

____

How do you believe your problem began? ______________________________________

____

Have you ever had this condition or something similar before? When? ________________

____

What makes it better? ____

What makes it worse? ____

Have you been under the care of another health care provider for this condition? When?

____

Do you have any other health concerns? ____

____

Have you ever been in any accidents (ie. Auto, falls from stairs or ladders), even as a child?

____

____

What surgeries have you had? ______________________________ Year: __________

______________________________ Year: __________

______________________________ Year: __________

Are you pregnant? __________ If yes what is your due date? ________________________

What medication are you taking? (Including aspirin, etc) __________________________

____

What vitamins and supplements do you take?___________________________________

____

Habits (Please check):

Cigarettes: ______ *Quantity*: _________ Alcohol: ________ *Quantity*: __________

Coffee: _________ *Quantity*: _________ Pop : ___________ *Quantity*: __________

Tea: ___________ *Quantity*: _________ Water: _________ *Quantity*: __________

Do you exercise? How often? Activities? ____

____

Have you lost or gained weight in the past year? How much? _______________________

How do you characterize your stress levels? (Please check):

______ High ______ Medium ______ Low

Do you have a family history of: (Please Mark M for mother, F for father, S for sibling)

_____ High Blood Pressure _____ Thyroid Disease _____ Stroke _____ Cancer

_____ Heart Disease _____ Headaches _____ Osteoporosis _____ Back Pain

_____ Depression or Anxiety _____ Stroke _____ Arthritis _____ Diabetes

Is there anything else in your health history that we should know? __________________

____

Have you had or do you now have any of the following symptoms which are or have been significant distress to you?

	Now	Past		Now	Past		Now	Past
Headaches	____	____	Shoulder Pain	____	____	Shoulder/Neck/Arm Pain	____	____
Loss of Balance	____	____	Swelling Joints	____	____	Pins & Needles in Arms	____	____
Neck Pain	____	____	Ears Ring	____	____	Pins & Needles in Legs	____	____
Stiff Neck	____	____	Colitis	____	____	Numbness in Fingers	____	____
Fainting	____	____	Sleeping Problems	____	____	Numbness in Toe	____	____
Back Pain	____	____	Loss of Smell	____	____	Dizziness	____	____
Nervousness	____	____	Loss of Taste	____	____	Difficulty Urinating	____	____
Tension	____	____	High Blood Pressure	____	____	Leg Cramps	____	____
Gall Bladder	____	____	Feet Cold	____	____	Weakness in Arms	____	____
Chest Pains	____	____	Hands Cold	____	____	Diarrhea	____	____
Upset Stomach	____	____	Arthritis	____	____	Menstrual Difficulties	____	____
Constipation	____	____	Weakness in Legs	____	____	Vomiting	____	____
Hemorrhoids	____	____	Muscle Spasms	____	____	Depression	____	____
Fever	____	____	Shortness of Breath	____	____	Loss of Memory	____	____
Sinus Problems	____	____	Frequent Colds	____	____	Knee Pain	____	____
Diabetes	____	____	Allergies	____	____	Indigestion	____	____

Have you ever had (circle): Heart Attack: **YES NO** Stroke: **YES NO** Back Surgery: **YES NO**

Neck Surgery: **YES NO** Hip Surgery: **YES NO** Knee Surgery: **YES NO**

LOWER EXTREMITIES

Do you avoid activity due to pain in your feet or lower extremities? _____ Yes _____No

Do you have to elevate your feet to get comfortable? _____ Yes _____No

Are your symptoms affected by walking, standing or climbing stairs? _____ Yes _____No

Do you use any type of home therapies for your feet and lower extremities? _____ Yes _____No

If yes, what therapies? : ____

Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
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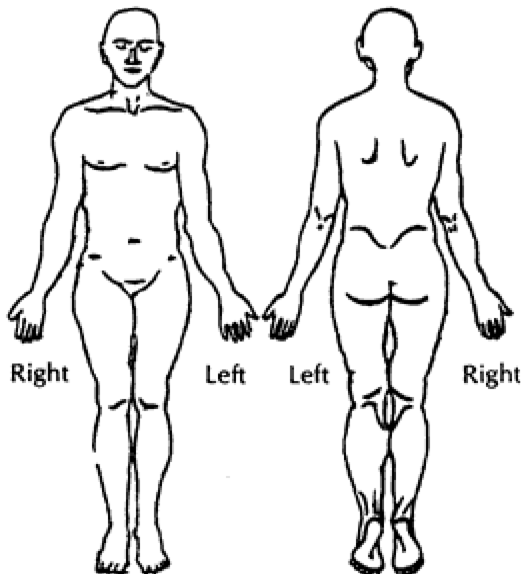
Please mark on the pain scale from Zero to 10 the pain you feel with this condition. 10 being the worst pain you have felt with this condition.



Neck- Shoulder - Arm Pain
On a scale of zero to ten I rate my discomfort as follows:
0 1 2 3 4 5 6 7 8 9 10
No pain Severe Pain

Mid Back Pain
On a scale of zero to ten I rate my discomfort as follows:
0 1 2 3 4 5 6 7 8 9 10
No pain Severe Pain

Low Back and Leg Pain
On a scale of zero to ten I rate my discomfort as follows:
0 1 2 3 4 5 6 7 8 9 10
No pain Severe Pain