

New Dimensions Chiropractic

New Patient Intake

Patient Name: _____
Last First M.I.
Preferred Name: _____ Sex: Male /Female
DOB: _____ Age: _____ SS# _____ - _____ - _____
Street Address: _____ Unit #: _____
City: _____ State: _____ Zip Code: _____ Mobile: _____
Home Phone: _____ Work Phone: _____ Email Address: _____
Who referred you? _____ Previous Chiropractic Patient? Y / N

Employer Information

Occupation: _____ Employer: _____
Employer Address: _____

Payment Method:

☐ Insurance ☐ Self Pay ☐ PIP ☐ W/C

Primary Insurance Carrier: _____
Name and DOB of Primary Insured: _____
ID and Group #: _____

History of Present Illness:

Major concern or complaint: _____

When did symptoms appear? _____

What caused your symptoms to appear? _____

What makes your pain better? _____

What makes your pain worse? _____

What type of pain are you experiencing: ☐ Sharp ☐ Dull ☐ Numb ☐ Stiff ☐ Achy ☐ Burning ☐ Shooting
☐ Stabbing ☐ Tingly ☐ Other

Does your pain travel to any other parts of your body? _____

Rate your average pain from 0 (no pain) to 10 (worst): _____

How frequent does your pain appear? (% of day) _____

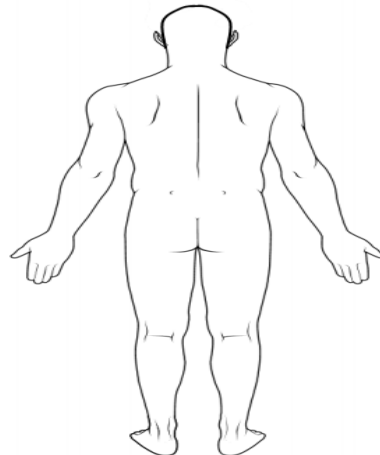
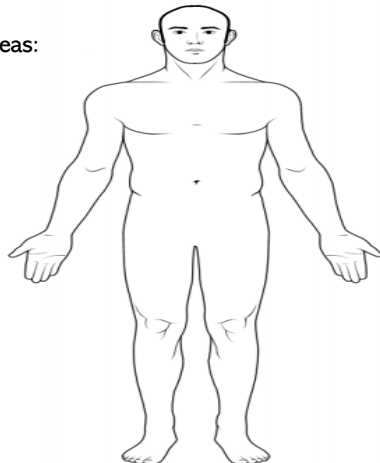
Does your symptoms seem to be getting ☐ Better ☐ Worst ☐ Same

Does pain interfere with daily activities? ☐ Y ☐ N

What treatment have you received for this condition? ☐ Meds ☐ PT ☐ Chiro ☐ Massage ☐ None

Any other associated symptoms or concerns: _____

Use figure to highlight problem areas:



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Past Medical History:

Past Hospitalizations: ☐ Yes ☐ No If yes, explain: _____

Past Surgeries: ☐ Yes ☐ No If yes, explain: _____

List Allergies: _____

Rx Medications (and reason): _____

Are you taking any of the following medications? If yes, how frequent?

☐ Nerve pills ☐ Pain killers [including aspirin] ☐ Insulin ☐ Blood thinners ☐ Muscle Relaxers

Name of Primary Care Physician: _____

Address: _____ Phone: _____

SYSTEMS REVIEW

Please *circle* any conditions that are *presently* causing you a problem and underline those that have caused you problems in the past.

<p style="text-align: center;">GENERAL SYMPTOMS</p> <p>Fever Sweats Fainting Sleep disturbance Fatigue Nervousness Weight loss Weight gain</p>	<p style="text-align: center;">RESPIRATORY</p> <p>Chronic cough Spitting up phlegm Spitting up blood Chest pain Wheezing Difficulty breathing Asthma</p>	<p style="text-align: center;">GENITOURINARY</p> <p>Frequent urination Painful urination Blood in urine Pus in urine Kidney infection Prostate trouble Uncontrollable urine flow</p>
<p style="text-align: center;">NEUROLOGICAL</p> <p>Visual disturbances Dizziness Fainting Convulsions Headache Numbness Neuralgia (nerve pain) Poor coordination Weakness</p>	<p style="text-align: center;">CARDIOVASCULAR</p> <p>Rapid beating heart Slow beating heart High blood pressure Low blood pressure Pain over heart Hardening of arteries Swollen ankles Poor circulation Palpitations Cold hands or feet Varicose veins</p>	<p style="text-align: center;">GASTROINTESTINAL</p> <p>Poor appetite Difficult digestion Heartburn Ulcers Nausea Vomiting Constipation Diarrhea Blood in stool Gallbladder/jaundice Colitis</p>
<p style="text-align: center;">EENT</p> <p>Eye pain Double vision Ringing in ears Deafness Nosebleeds Trouble swallowing Hoarseness Sinus infection Nasal drainage Enlarged glands</p>	<p style="text-align: center;">MUSCLE & JOINT</p> <p>Neck pain Low back pain Arm pain Shoulder pain Leg pain Knee pain Foot pain Pain/numbness down arms or legs Pain between shoulders Swollen joints Spinal curvature Arthritis Fractures</p>	<p style="text-align: center;">FOR WOMEN ONLY</p> <p>Painful menstruation Hot flashes Irregular cycle Cramps or back pain Vaginal discharge Nipple discharge Lumps in breast Menopausal symptoms Birth control pills Miscarriages Complications with pregnancy Pregnant? Y / N Week? Other:</p>

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Family History: ☐Heart disease ☐Cancer ☐Lupus ☐ALS ☐RA ☐Diabetes ☐Other

Social History:

Have you used any of the following substances?

	Current	Previous	Amount/Frequency/Duration
Caffeine: coffee, tea, soda	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Tobacco	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Alcohol – beer, wine, liquor	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Recreational/Street drugs	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____

Have you ever been physically, sexually, or emotionally abused? ☐No ☐Yes
Do you participate in unsafe sexual practices? ☐No ☐Yes
Are you taking any supplements? ☐No ☐Yes
Do you drink water daily? ☐No ☐Yes
What is your activity level? None Light Moderate Intense

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed
Spouse's Name: _____ Phone: _____
Emergency Contact: _____ Phone: _____

What's Most Important? 1=least 5=most

Getting my issue resolved	1	2	3	4	5
Getting in and out quickly as possible	1	2	3	4	5
Knowing all aspects of my care	1	2	3	4	5
Understanding root/cause of my condition	1	2	3	4	5
Knowing more about Chiropractic	1	2	3	4	5
Preventive care to prevent further occurrences	1	2	3	4	5

In Addition to Chiropractic Care, I am also interested in:

☐Massage ☐Diet/Weight Loss ☐Vitamins/Supplements ☐Acupuncture

Activity Level: ☐None ☐Light ☐Moderate ☐Intense

Goals of treatment: _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Thank you for choosing New Dimensions Chiropractic Center!!