Date_____ Patient Full Name:_____ Date of Birth:_____

NEW PATIENT PRESENTING HEALTH COMPLAINTS

Purpose Of This Appointment/Your Major Area/s Of Discomfort/Complaint_____

Is Your Complaint Caused by (Circle Your Choice): - Unknown Cause - Job Injury -Auto Accident or Other:_____

Date You Noticed Complaint/s:_____ (Notify Front Desk Immediately For Job & Auto injuries)

Have you Previously Experienced Similar Complaint/s? __NO __YES; WHEN? _____

Have you had **x-rays** or **MRI** of your complaint region/s? __NO __YES; WHEN/WHERE? _____

_____

What Aggravates Your Complaint/s? **(Please circle all that apply)**

coughing/sneezing	reaching	standing/arising to stand
bending	walking	straining at stool
sitting/arising	head feels heavy	turning over in bed
getting out of bed	neck movement	lying down on your side
lifting	sleeping	other _____

What Gives Relief To Your Complaint/s? **(Please circle all that apply)**

lying down	prescription meds	over the counter meds
nothing	reclining	sitting
rest	stretching	standing
ice/heat	moving	massage
walking	exercise	Other:_____

Please list all the treatments you have received for your condition and their approximate dates:

_____

_____

What Do You Sleep On: __Waterbed __Mattress **Normally sleep on**:___Back ___Side ___Stomach

Is Your Bed Firm? __Yes __No Comfortable? Yes – No

Date of your last Chiropractic visit: _____

Name of your Medical Doctor:_____

Address of your Medical Doctor: _____

Date of last MD Visit_____ Reason for Visit:_____

Please List all Medications & Supplements You Take Presently_____

_____

_____