Creekside Chiropractic

New Patient History

Date:_____

Name:_____

Home Phone:_____ Cell Phone:_____

Social Security #:_____ Birthdate:_____ Age:_____

Email Address:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Please circle the best way to contact you: Email / Text / Home-Cell – Work Number

Occupation:_____ Employer:_____

Work Address:_____ Work Phone:_____

Marital Status:

- ❑ *Single*
- ❑ *Married*
- ❑ *Divorced*
- ❑ *Other*

Spouse's Name:_____ Children: 0 1 2 3 4 5+

Emergency contact name and number:_____

Who may we thank for referring you:_____

Insurance Information:

Is your condition due to:

- ❑ An Auto Accident
- ❑ A Personal Injury
- ❑ Work Injury

Health Insurance Company _____

Policy # _____

Spouse's Insurance Company _____

Policy # _____

Please sign here to authorization the release of records to your insurance carrier

X _____ Date: _____

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Please begin by letting us know what symptoms are giving you trouble.
Check all that apply.

1. Misc:
   - ❑ Headaches
   - ❑ TMJ

2. Spinal:
   - ❑ Neck Pain
   - ❑ Mid Back Pain
   - ❑ Low Back Pain
   - ❑ Neck Stiffness
   - ❑ Mid Back Stiffness
   - ❑ Low Back Stiffness

3. Upper:
   - ❑ Left Shoulder Pain
   - ❑ Right Shoulder Pain
   - ❑ Left Arm Pain
   - ❑ Right Arm Pain
   - ❑ Left Wrist Pain
   - ❑ Right Wrist Pain
   - ❑ Left Hand Pain
   - ❑ Right Hand Pain
   - ❑ Radiating Pain to the left Shoulder
   - ❑ Radiating Pain to the right Shoulder
   - ❑ Radiating Pain to the left Arm
   - ❑ Radiating Pain to the right Arm
   - ❑ *Numbness* and *Tingling* into the left Hand
   - ❑ *Numbness* and *Tingling* into the right Hand

4. Lower:
   - ❑ Back left hip pain
   - ❑ Back right hip pain
   - ❑ Left Hip Pain
   - ❑ Right Hip Pain
   - ❑ Left Leg Pain
   - ❑ Right Leg Pain
   - ❑ Left Knee Pain
   - ❑ Right Knee Pain
   - ❑ Left Foot Pain
   - ❑ Right Foot Pain
   - ❑ Radiating Pain into the left Buttocks
   - ❑ Radiating Pain into the right Buttocks
   - ❑ Radiating Pain into the left Leg
   - ❑ Radiating Pain into the right Leg
   - ❑ Radiating Pain into left Foot
   - ❑ Radiating Pain into right Foot
   - ❑ *Numbness* and *Tingling* into left Foot
   - ❑ *Numbness* and *Tingling* into right Foot

5. Other Symptoms: _____
   _____
   _____

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6. About when did your symptoms begin? _____

7. How did your symptoms begin?

- ❑ Not doing anything at the time of onset
- ❑ Motor Vehicle Accident
- ❑ Work Injury
- ❑ Overexertion
- ❑ Strenuous Position
- ❑ Fell
- ❑ Lifting
- ❑ Other_____ _____

8. How soon did the symptoms come on?

- ❑ Immediately
- ❑ A week Later
- ❑ A Few Hours Later
- ❑ Slowly over time
- ❑ A few Days Later

9. What seems to **aggravate** your condition?

- ❑ Nothing
- ❑ Coughing
- ❑ Bending
- ❑ Lifting
- ❑ Walking
- ❑ Reaching
- ❑ Sitting
- ❑ Standing
- ❑ Pulling
- ❑ Turning
- ❑ Other:_____

10. What seems to **alleviate** your condition?

- ❑ Nothing
- ❑ Rest
- ❑ Sitting
- ❑ Stretching
- ❑ Exercise
- ❑ Standing
- ❑ Ice
- ❑ Heat
- ❑ Medication_____
- ❑ Other _____

11. How would you **characterize** your pain? *(Please check all that apply)*

- ❑ Burning
- ❑ Dull
- ❑ Sharp
- ❑ Shooting
- ❑ Aching
- ❑ Throbbing
- ❑ Other_____

12. Does your pain **radiate** to any o f the following areas?

- ❑ None
- ❑ Left Shoulder
- ❑ Right Shoulder
- ❑ Left Arm
- ❑ Right Arm
- ❑ Left Hand
- ❑ Right Hand
- ❑ Left Buttock
- ❑ Right Buttock
- ❑ Left Leg
- ❑ Right Leg
- ❑ Left Foot

- ❑ Right Foot
- ❑ Other_____

13. Are you experiencing any ***numbness* or *tingling***?

- ❑ None
- ❑ Left Shoulder
- ❑ Right shoulder
- ❑ Left Arm
- ❑ Right Arm
- ❑ Left Hand
- ❑ Right Hand
- ❑ Left buttocks
- ❑ Right Buttocks
- ❑ Left Leg
- ❑ Right Leg
- ❑ Left Foot
- ❑ Right Foot
- ❑ Other_____

14. Please rate your pain today on a scale of 0-10 (0= no pain and 10= your worst pain ever)

0 1 2 3 4 5 6 7 8 9 10

15. At what time of day are your symptoms **worst**?

- ❑ None
- ❑ Morning
- ❑ Afternoon
- ❑ Evening
- ❑ While Awake
- ❑ While Sleeping

16. At what time of day are your symptoms **best**?

- ❑ None
- ❑ Morning
- ❑ Afternoon
- ❑ Evening
- ❑ While Awake
- ❑ While Sleeping

17. Have you seen anyone else for this condition?

- ❑ No
- ❑ Chiropractor
- ❑ MD
- ❑ Physical Therapist
- ❑ Specialist _____
- ❑ Other_____

18. Name and Location:_____

Name and Location:_____

19. What happened to your condition as a result of that treatment?

- ❑ Resolved
- ❑ Went Unresolved
- ❑ Improved but not to an Acceptable Level
- ❑ Worsened

20. Who is your primary? _____

MEDICAL HISTORY

21. Please list any allergies:_____

22. Do you have a history of any of the following? ❑ **Yes** ❑ **No**

❑ Work Injury ❑ Motor Vehicle Accident ❑ Slip and Fall Accident

23. If so, please list approximate dates and incidents of the injuries

1) Date:_____ Incident:_____
2) Date:_____ Incident:_____
3) Date:_____ Incident:_____
4) Date:_____ Incident:_____

24. Have you ever been hospitalized? ❑ **No** ❑ **Yes** If so. when and for what condition?

1) Date:_____ Condition:_____
2) Date:_____ Condition:_____
3) Date:_____ Condition:_____
4) Date:_____ Condition:_____

25. Have you had any surgeries? ❑ **No** ❑ **Yes** If so. when and for what surgery?

1) Date:_____ Surgery :_____
2) Date:_____ Surgery :_____
3) Date:_____ Surgery :_____
4) Date:_____ Surgery :_____

How does this problem interfere with the following areas of your life?

WORK: _____

FAMILY: _____

HOBBIES: _____

LIFE: _____

On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem: _____

REVIEW OF SYSTEMS

Are you currently suffering from any of the problems below?

- ❑ General Fatigue
- ❑ Weakness Fever (continuous)
- ❑ Loss of Sleep
- ❑ Chills (continuous)
- ❑ Weight change
- ❑ Night sweats

- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Convulsions
- ❑ Nervousness

- ❑ Anxiety
- ❑ Depression (prolonged)
- ❑ Phobias (excessive fears)
- ❑ Memory loss or impairment
- ❑ Mood swings (excessive)

- ❑ Hearing trouble
- ❑ Ringing in ears
- ❑ Pain in ears
- ❑ Ear discharge
- ❑ Vision trouble
- ❑ Pain in eyes
- ❑ Eye discharge

- ❑ Nose/sinus pain,
- ❑ Excessive drainage
- ❑ Nose bleeds (chronic)
- ❑ Nasal infections (chronic)
- ❑ Absence of smell

- ❑ Mouth sores,
- ❑ Bleeding gums
- ❑ Enlarged glands
- ❑ Absence of taste
- ❑ Abnormal taste sensation
- ❑ Tonsillitis/infected tonsils
- ❑ Difficulty swallowing

- ❑ Heat/cold intolerance
- ❑ Sugar in urine
- ❑ Goiter (enlarged thyroid gland)
- ❑ Tremor (shaking)

- ❑ Skin rash
- ❑ Redness of skin
- ❑ Skin itching
- ❑ Skin dryness
- ❑ Eczema (red/inflamed skin)
- ❑ Hair changes
- ❑ Nail changes
- ❑ Bruise easily

- ❑ Varicosities (visible veins)
- ❑ Blue extremities
- ❑ Swollen extremities
- ❑ Difficulty breathing
- ❑ Wheezing (chronic)
- ❑ Cough (chronic)
- ❑ Rapid heart beat
- ❑ Chest pain
- ❑ Heart palpitations
- ❑ Heart murmur

- ❑ Decreased appetite
- ❑ Increased appetite
- ❑ Abdominal pain
- ❑ Hemorrhoids
- ❑ Excessive gas
- ❑ Vomiting (excessive)
- ❑ Diarrhea (excessive)
- ❑ Constipation (excessive)
- ❑ Heartburn/indigestion

- ❑ Prostate problems
- ❑ Painful urination
- ❑ Inability to hold urine
- ❑ Frequent urination
- ❑ Bed-wetting
- ❑ Irregular menstruation
- ❑ Painful menstruation
- ❑ Abnormal vaginal bleeding
- ❑ Sterility

- ❑ Impotence
- ❑ Lumps in breast(s)
- ❑ Redness/itching of breast
- ❑ Dimpling of breast(s)
- ❑ Discharge from breast(s)
- ❑ Breast pain

Printed Name: _____ Relationship to Patient: _____

X_____ ***Date:***_____

(Please sign to certify that the above information is true to the best of your knowledge)

For Women Only

Date of your last menstrual period: _____

Are using any means of contraception? _____

Do you experience severe cramping with your menstrual period? __

Do you suffer from PMS? _____

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Accident/Injury/ Work Related/ Questionnaire

Date:_____

Name: _____

1. What date did your accident/injury occur? _____
2. Please Describe in your own words what happened._____

   _____

   _____
3. Did you lose Consciousness?
   - ❑ **Yes**
   - ❑ **No**
4. How did you feel?
   - ❑ **Painful**
   - ❑ **Fine**
   - ❑ **Dazed**
   - ❑ **Confused**
   - ❑ **Weak**
   - ❑ **Dizzy**
   - ❑ **Other _____**
5. Immediately after the accident where did you develop pain?
   - ❑ **Head**
   - ❑ **Neck**
   - ❑ **Upper back**
   - ❑ **Mid back**
   - ❑ **Low back**
   - ❑ **Pelvis**
   - ❑ **Chest**
   - ❑ **Rib cage**
   - ❑ **Abdomen**
   - ❑ **Left upper extremity**
   - ❑ **Right upper extremity**
   - ❑ **Left lower extremity**
   - ❑ **Right lower extremity**
6. Did you receive emergency care?
   - ❑ **Yes**
   - ❑ **No**
7. Where did you go after the accident?
   - ❑ **Hospital**
   - ❑ **Home**
   - ❑ **School**
   - ❑ **Work**
   - ❑ **Other:_____**
8. Who drove you?
   - ❑ **Ambulance**
   - ❑ **Family member**
   - ❑ **Yourself**
   - ❑ **A friend**

[Turn Over]

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9. Did additional symptoms develop?
   - ❑ **No**
   - ❑ **Head**
   - ❑ **Neck**
   - ❑ **Upper back**
   - ❑ **Mid back**
   - ❑ **Low back**
   - ❑ **Legs**
   - ❑ **Arms**
10. When did additional symptoms develop?
   - ❑ **Immediately**
   - ❑ **Hours later**
   - ❑ **A few days later**
   - ❑ **In a week**
   - ❑ **In a month**
   - ❑ **The next day**
11. Did you go to the hospital?
   - ❑ **Yes**
   - ❑ **No**
12. Name and location of hospital _____

_____

13. When did you go to the hospital?
   - ❑ **Immediately**
   - ❑ **Later that day**
   - ❑ **Next day**
   - ❑ **The next month**
14. At then hospital did you have any of the following?
   - ❑ **X-ray**
   - ❑ **MRI**
   - ❑ **CT scans**
   - ❑ **None**
15. Of what body area were the images taken?
   - ❑ **Head**
   - ❑ **Neck**
   - ❑ **Upper back**
   - ❑ **Mid back**
   - ❑ **Low back**
   - ❑ **Pelvis**
   - ❑ **Chest**
   - ❑ **Rib cage**
   - ❑ **Abdomen**
   - ❑ **Left upper extremity**
   - ❑ **Right upper extremity**
   - ❑ **Left lower extremity**
   - ❑ **Right lower extremity**
16. Describe what treatment was given at the hospital? _____

_____

17. Have you missed work because of this accident?
   - ❑ **Yes** *Please give dates:* _____
   - ❑ **No**

X_____ ***Date:***_____

(Please sign to certify that the above information is true to the best of your knowledge.)

Printed Name: _____

Relationship to Patient:_____