

# Pathway Wellness Chiropractic Clinic

Tallahassee, FL

## New Patient History Form

Last Name _____	First Name _____	Date _____
Social Security # _____	Birth Date _____	Age _____
Address _____	City _____	State _____ Zip _____
Home Phone _____	Work Phone _____	Cell Phone _____
Email address _____	Would you like appt. reminders emailed _____	
Occupation _____	Primary Care Physician _____	
A majority of your work day is spent? _____ Standing _____ Sitting _____ Walking _____ Varied		
Marital Status _____	No. of Children _____	
Have you ever been to a chiropractic clinic before? _____ If Yes: When _____		
For What Condition? _____		
How did you respond to treatment? _____		
How did you hear about our clinic? _____		

### Section A. Describe your complaints in order of severity (1<sup>st</sup> complaint, 2<sup>nd</sup> complaint, etc...)

<b>1<sup>st</sup> Complaint</b> _____	<b>Date Started</b> _____
What is the history of this injury or symptom? _____ _____ _____ _____ _____ _____ _____	
What makes your problem worse? _____ _____	
What makes your problem better? _____	
How would you describe your pain? _____	
What is the location or radiation of your pain? _____ _____	
How bad is your pain on a scale of 0 to 10? (0=no pain and 10=unbearable pain) Now: ___/10      Average: ___/10      Best: ___/10      Worst: ___/10	
What time of the day or week are your symptoms worse? _____	
How often are your symptoms present? <input type="checkbox"/> Intermittently <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/> Constant	
What daily activities have been affected? _____	
Does this pain wake you from sleep? Yes / No    Does it affect your sleep at all    Yes / No	
Have you received any treatment for this condition and if so what? _____ _____ _____ _____	

Patient Name \_\_\_\_\_  
Date \_\_\_\_\_

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**2<sup>nd</sup> Complaint** \_\_\_\_\_ **Date Started** \_\_\_\_\_

What is the history of this injury or symptom? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What makes your problem worse? \_\_\_\_\_

What makes your problem better? \_\_\_\_\_

How would you describe your pain? \_\_\_\_\_

What is the location or radiation of your pain? \_\_\_\_\_

How bad is your pain on a scale of 0 to 10? (0=no pain and 10=unbearable pain)

Now: \_\_\_/10      Average: \_\_\_/10      Best: \_\_\_/10      Worst: \_\_\_/10

What time of the day or week are your symptoms worse? \_\_\_\_\_

How often are your symptoms present?     Intermittently     Occasionally     Frequently     Constant

What daily activities have been affected? \_\_\_\_\_

Have you received any treatment for this condition and if so, what? \_\_\_\_\_

**Section B** Please use a **yes** or **no** when answering any of the following. If you are not sure leave a ? .

\_\_\_ Do you have a past history of cancer?

\_\_\_ Have you had any unexplained weight loss?

\_\_\_ Does your pain not improve with rest?

\_\_\_ No response to 4-6 weeks of conservative care?

\_\_\_ Have you had spinal pain greater than 4 weeks?

\_\_\_ Recent trouble starting or stopping urination?

\_\_\_ Trouble starting or stopping bowel movements?

\_\_\_ Numbness in the groin region?

\_\_\_ Increasing muscle weakness in the legs?

\_\_\_ History of significant trauma?

\_\_\_ Minor trauma in person >50 years old?

\_\_\_ Do you have osteoporosis (weak bones)?

\_\_\_ Are you over 70 years old?

\_\_\_ Any history of prolonged use of corticosteroids?

\_\_\_ Intravenous drug use?

\_\_\_ Current or recent infection (urinary, respiratory, etc)?

\_\_\_ Immunosuppression medication &/or condition?

### PAST HISTORY

**PREVIOUS INJURIES** (Please give dates, describe injury and care received)

**AUTO:** \_\_\_\_\_  
\_\_\_\_\_

**WORK RELATED:** \_\_\_\_\_  
\_\_\_\_\_

**PERSONAL:** \_\_\_\_\_  
\_\_\_\_\_

**SPORTS INJURY:** \_\_\_\_\_  
\_\_\_\_\_

**CURRENT MEDICAL CONDITIONS:** ie. (diabetes, hypertension, etc)

**LIST ALL MEDICATIONS/VITAMINS:**

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

**X** \_\_\_\_\_ **Date** \_\_\_\_\_  
**Signature of patient (or parent of minor)**

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

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## New Patient History Form REVIEW OF SYSTEMS

Please use the numbers below when answering. If you have never had the condition please leave blank.

1. Current

2. Past

3. Related to accident

### GENERAL SYMPTOMS

\_\_\_ 784.0 Headache  
\_\_\_ 780.6 Fever  
\_\_\_ 780.99 Chills  
\_\_\_ 780.8 Night Sweats  
\_\_\_ 780.2 Fainting  
\_\_\_ 780.4 Dizziness  
\_\_\_ 780.3 Convulsions  
\_\_\_ 780.52 Loss of Sleep  
\_\_\_ 780.7 Fatigue  
\_\_\_ 799.2 Nervousness  
\_\_\_ 783.0 Loss of Weight  
\_\_\_ 782.0 Numbness or pain  
in arms/legs/hands  
\_\_\_ 995.3 Allergy (What)  
\_\_\_ 786.07 Wheezing  
\_\_\_ 729.2 Neuralgia

### MUSCLE & JOINTS

\_\_\_ 728.9 Weakness  
\_\_\_ 781.0 Twitching  
\_\_\_ 723.5 Stiff Neck  
\_\_\_ 724.5 Backache  
\_\_\_ 719.0 Swollen Joints  
\_\_\_ 781.0 Tremors  
\_\_\_ 729.5 Foot Trouble  
\_\_\_ 724.79 Painful Tailbone  
\_\_\_ 724.5 Pain Between  
Shoulders  
\_\_\_ 737.3 Spinal Curvature

### GASTRO-INTESTINAL

\_\_\_ 783.0 Poor Appetite  
\_\_\_ 536.8 Poor Digestion  
\_\_\_ 994.2 Starvation  
\_\_\_ 787.3 Belching or Gas  
\_\_\_ 787.0 Nausea  
\_\_\_ 787.0 Vomiting  
\_\_\_ 578.0 Vomiting Blood  
\_\_\_ 536.8 Pain over Stomach  
\_\_\_ 564.0 Constipation  
\_\_\_ 787.91 Diarrhea  
\_\_\_ 562.1 Colon Trouble  
\_\_\_ 455.6 Hemorrhoids  
\_\_\_ 776.7 Fluid Retention  
\_\_\_ 873.9 Liver Trouble  
\_\_\_ 274.0 Gout  
\_\_\_ 782.4 Jaundice  
\_\_\_ 575.9 Gall - Bladder  
Trouble

### CARDIO VASCULAR

\_\_\_ 785.0 Rapid Heart  
\_\_\_ 427.89 Slow Heart  
\_\_\_ 401.9 High Blood Pressure  
\_\_\_ 458.9 Low Blood Pressure  
\_\_\_ 786.51 Pain Over Heart  
\_\_\_ 429.9 Heart Trouble  
\_\_\_ 719.07 Swelling Ankles  
\_\_\_ 459.9 Poor Circulation

\_\_\_ 454.9 Varicose Veins  
\_\_\_ 436.0 Strokes  
\_\_\_ 785.1 Palpitations

### EYE/EAR/NOSE/THROAT

\_\_\_ 368.9 Poor Vision  
\_\_\_ 378.0 Crossed Eyes  
\_\_\_ 379.91 Pain in Eyes  
\_\_\_ 389.9 Deafness  
\_\_\_ 388.70 Earache  
\_\_\_ 388.30 Ear Noises  
\_\_\_ 388.60 Ear Discharges  
\_\_\_ 478.1 Nasal Obstruction  
\_\_\_ 784.7 Nose Bleeds  
\_\_\_ 462.0 Sore Throats  
\_\_\_ 784.49 Hoarsness  
\_\_\_ 477.9 Hay Fever  
\_\_\_ 493.9 Asthma  
\_\_\_ 460.0 Frequent Colds  
\_\_\_ 240.9 Enlarged Thyroid  
\_\_\_ 465.0 Tonsillitis  
\_\_\_ 473.0 Sinus Trouble

### SKIN/ALLERGIES

\_\_\_ 680.0 Skin Eruptions  
\_\_\_ 698.9 Itching  
\_\_\_ 924.9 Bruising Easily  
\_\_\_ 701.1 Dryness  
\_\_\_ 680.9 Boils  
\_\_\_ 782.0 Sensitive Skin

\_\_\_ 708.9 Hives or Allergies  
\_\_\_ 692.9 Eczema

### RESPIRATORY

\_\_\_ 786.2 Chronic Cough  
\_\_\_ 786.2 Spitting Blood  
\_\_\_ 786.4 Spitting Phlegm  
\_\_\_ 786.5 Chest Pain  
\_\_\_ 786.09 Difficult Breathing

### GENITO-URINARY

\_\_\_ 788.4 Frequent Urination  
\_\_\_ 788.1 Painful Urination  
\_\_\_ 599.7 Blood in Urine  
\_\_\_ 590.0 Kidney Infection  
\_\_\_ 788.3 Bed Wetting  
\_\_\_ 788.3 Inability to control  
Urine  
\_\_\_ 601.9 Prostate Trouble

### FOR WOMEN ONLY

\_\_\_ 625.3 Painful Periods  
\_\_\_ 626.2 Excessive Flow  
\_\_\_ 626.4 Irregular Cycle  
\_\_\_ 627.2 Hot Flashes  
\_\_\_ 625.3 Cramps or Backaches  
\_\_\_ 623.5 Vaginal Discharge  
Last Pap Exam

Other conditions not listed above:

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I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Date \_\_\_\_\_

Signature of patient (or parent of minor)

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

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