

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 (1st complaint, 2nd complaint, etc...)

1st 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? <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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2nd 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:

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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