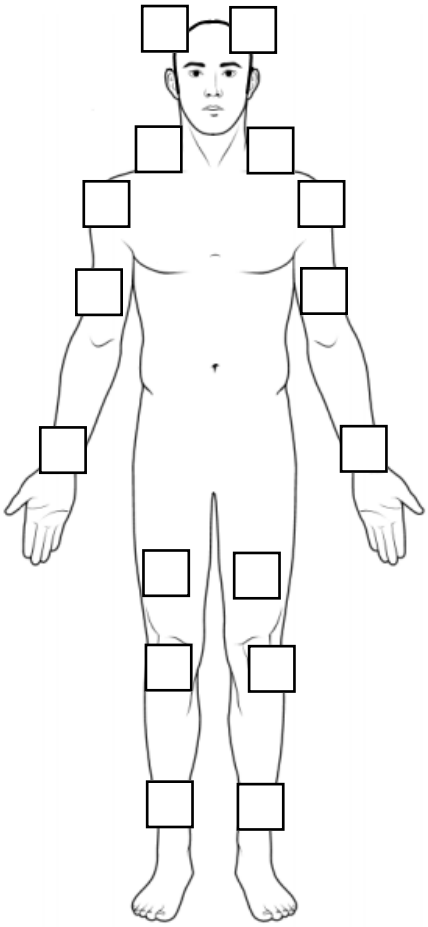
Pathway Wellness Chiropractic Clinic

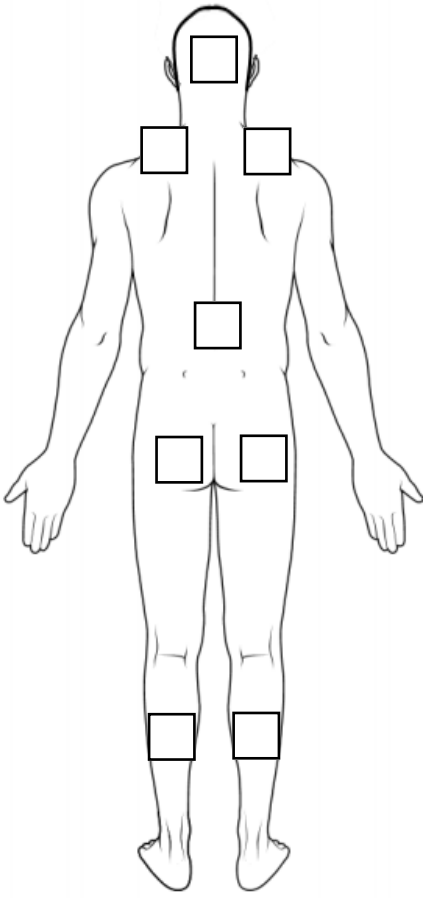
Tallahassee, FL

New Patient History Form

Last Name_____ First Name_____ Date_____
Last 4 of SSN_____ Birth Date _____/_____/_____
Address_____ City _____ State_____ Zip_____
Primary Phone Number _____ Cell Phone Carrier _____
Email address_____
Insurance Company _____ _____
How did you hear about our clinic? _____ Have you been to a chiropractor before?_____
If yes how did you respond_____

Please Mark Your Areas of Pain on the Diagram Below





Type of Pain:

- ☐ Sharp/Stabbing
- ☐ Burning
- ☐ Ache
- ☐ Dull
- ☐ Numb/Tingling
- ☐ Other _____

Describe your main concern below:

Pathway Wellness Chiropractic Clinic

Tallahassee, FL

New Patient History Form

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 personal history of cancer?

___ Have you had any unexplained weight loss?

___ Recent trouble starting or stopping urination?

___ Recent trouble with bowel movements?

___ Numbness in the groin region?

___ Recent muscle weakness in the legs?

___ History of significant trauma?

___ Do you have osteoporosis?

___ History of prolonged use of corticosteroids?

___ Do you have a connective tissue disorder?

___ Current or recent infection?

___ History of immunosuppression medication &/or condition?

___ Do you have hypertension?

___ Do you smoke?

PAST HISTORY

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

AUTO: _____
_____

WORK RELATED: _____
_____

PERSONAL: _____
_____

LIST ALL SURGERIES: _____
_____

CURRENT MEDICAL CONDITIONS: ie. (diabetes, high blood pressure, high cholesterol, etc)
_____
_____

LIST ALL MEDICATIONS/VITAMINS:
_____
_____
_____
_____

Pathway Wellness Chiropractic Clinic

Tallahassee, FL

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. Related to auto accident

GENERAL SYMPTOMS
_____Headache
_____ Fever
_____ Chills
_____Night Sweats
_____Fainting
_____Dizziness
_____Fatigue
_____Nervousness
_____Loss of Weight
_____Numbness or pain in arms/legs/hands

MUSCLE & JOINTS
_____Weakness
_____Stiff Neck
_____Backache
_____Swollen Joints

GASTRO-INTESTINAL
_____Nausea
_____Vomiting
____Vomiting Blood
____Constipation
_____Diarrhea

CARDIO VASCULAR
_____ High Blood Pressure
_____Low Blood Pressure
_____Heart Trouble
_____Swelling Ankles
_____Poor Circulation
_____Varicose Veins
_____Strokes

EYE/EAR/NOSE/THROAT
_____Poor Vision
_____Pain in Eyes
_____Earache
_____Ear Noises
_____Nose Bleeds

SKIN/ALLERGIES
_____Bruising Easily
_____Sensitive Skin
_____Hives or Allergies
_____Eczema

RESPIRATORY
_____Chronic Cough
_____Spitting Blood
_____Chest Pain
_____Difficult Breathing

GENITO-URINARY
_____Painful Urination
_____Blood in Urine
_____Kidney Infection
_____Inability to control urine

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)