New Patient Form

Personal Information

Patients First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Email: _____

Employer Name: _____ City, State: _____

Spouse

Marital Status: ☐ Single ☐ Married ☐ Other Is spouse a patient at Infinite Health Chiropractic? Yes / No

Spouses First Name: _____ Spouses Last Name: _____

Home Phone: _____ Cell Phone: _____

Birth Date: _____

Emergency Contact:

Name: _____ Phone: _____

How did you hear about our office? _____

Have you ever had Chiropractic care before? Yes / No

If yes, please tell us the doctor's name _____

Were you pleased with your care? Yes / No

Are you receiving care from another health professional? Yes / No

If yes, please name them and their specialty _____

Who is your family's primary care physician? _____

Please list any drugs or medications you are taking _____

_____

List any vitamins/herbs/homeopathic you're taking _____

Instructions

Throughout today's exam, your doctor will be searching for one thing: the CAUSE of your health challenge. Chiropractic wellness care seeks to find the cause of a health challenge, rather than simply tying to artificially alleviate the symptoms through chemical manipulation. The following questions are vital to finding the cause of your current health condition and finding the cause of your current health condition and finding solutions to your health challenge. Please take your time answering these questions, including anything that you may feel is related to your current complaints. At Infinite Health Chiropractic, we have set the bar high and expect nothing but the best results for you. In order to properly begin that process, having a detailed history is a must, so if necessary please use an additional sheet of paper to answer these questions.

Questions

If possible, please fill out thoroughly and complete all forms and submit to Infinite Health Chiropractic for review at least 24 hours prior to the day your initial exam is scheduled.

1. How would you rate your current health status? Excellent / Good / Average / Poor
2. Where would you like your health to be? Excellent / Good / Average / Poor
3. What health challenge brings you to our office?

   _____
4. When did the symptoms first begin? _____
5. Did the problem start Suddenly / Gradually / Post-Injury
6. What makes the problem better? _____
7. What makes the problem worse? _____
8. Have you been treated for this condition before? Yes / No
9. Do you feel your current dietary and exercise habits are related to your health challenge? If so, please explain. _____
10. Do you feel there may be a physical cause related to your present health challenge? If so, please explain. _____
11. Do you feel there may be a mental or emotional component to your present health challenge? If so, please explain. _____
12. How do you feel your present health challenge affects your overall health and ability to experience an optimal quality of life? _____
13. How would your life be different if you no longer experienced your health challenge?

    _____
14. How would you describe your overall health status prior to this present health challenge?

    _____
15. Other than today's presenting complaint, please list any and all concerns regarding your health.

    _____
16. What is your medical provider's plan for you to experience optimal health and wellness?

    _____
17. Have you ever been checked for vertebral subluxation? Yes / No / Don't Know

Goals

What are your primary health goals?

_____

_____

Current height: _____ Current weight: _____

Past Surgeries: please list any past surgeries and when they were done

_____

_____

Medical History

Allergies:

___Eggs ___ Fish and Shellfish ___ Milk or Lactose ___ Peanuts

___ Soy ___Sugar ___ Sulfites ___ Wheat / Gluten

Social History:

How much caffeine do you consume in a day? (Soda, coffee, tea, ect) _____

How many alcoholic beverages do you consume per day/week? _____

How often do you use chewing tobacco? _____

How often do you use recreational drugs? _____

How many packs of cigarettes do you smoke a week? _____

How often do you exercise in a week? _____

How often are you stressed? _____

Family History:

___Arthritis (Parent or Sibling) ___Cancer (Parent or Sibling) ___Cholesterol (Parent or Sibling)

___Diabetes (Parent or Sibling ___Psychiatric (Parent or Sibling) ___Stroke (Parent or Sibling)

___Thyroid (Parent or Sibling) ___Heart problems (Parent or Sibling)

___High blood Pressure (Parent or Sibling)

Substance Use:

___Alcohol (Past or Present) ___Cocaine (Past or Present) ___Heroine (Past or Present)

___Barbiturates (Past or Present) ___Marijuana (Past or Present) ___Amphetamines (Past or Present)

Children: name and age

_____

_____

Symptom Questionnaire

Rate each of the following symptoms based upon how they apply to you.
1=Mild Symptoms (occurs once or twice a year)
2=Moderate Symptoms (occurs several times a year)
3=Severe Symptoms (you are aware of it almost constantly)

I.

☐Acid foods upset
☐Get chilled often
☐Dry mouth/eyes/nose
☐Unable to relax; startles easy
☐Urine amount reduced
☐Cold sweats often
☐Staring, blinks little
☐Gag easily
☐"Lump" in throat
☐Pulse speeds after meal
☐Extremities cold/clammy
☐Heart pounds after resting
☐Fever easily raised
☐Frequent sour stomach
☐Appetite reduced
☐Cuts heal slowly
☐Keyed up – fail to calm
☐Strong light irritates
☐"Nervous" stomach
☐Neuralgia-like pain

II.

☐Joint stiffness after arising
☐Muscle (leg-toe) cramp at night
☐Eyes blink often
☐Always seem hungry
☐Hoarseness frequently
☐Gag reflex slow
☐Get "chilled" infrequently
☐Subject to colds, asthma, bronchitis
☐Digestion rapid
☐"Butterfly" stomach cramps
☐Eyelids swollen or puffy
☐Feel light headed often
☐Breathing irregular
☐Difficulty swallowing
☐Perspires easily
☐"Slow starter"
☐Eyes/nose watery
☐Indigestion soon after meals
☐Vomiting frequently
☐Pulse slows; feels 'irregular'
☐Constipation/diarrhea alternate
☐Circulation poor, sensitive to cold

III.

☐Eat when nervous
☐Excessive appetite
☐Hungry between meals
☐Irritable before meals
☐Get "shaky" if hungry
☐Fatigue, eating relieves
☐Heart Palpitates if meals missed or delayed
☐Afternoon headaches
☐Overeating sweets upsets stomach
☐Awaken after few hours sleep and hard to get back to sleep
☐Crave candy/coffee in afternoons
☐Moods of depression – 'blues' or melancholy
☐Abnormal craving for sweets/snacks
☐"Lightheaded" if meals delayed

IV.

☐Hands and feet go to sleep easily, numbness
☐Sigh frequently
☐Aware of breathing heavily
☐High altitude discomfort
☐Open windows in closed room
☐Susceptible to colds and fevers
☐Get drowsy often
☐Swollen ankles worse at night
☐Muscle cramps worse during exercise; "charley horses"
☐Shortness of breath on exertion
☐Dull pain in chest or radiating into left arm, worse on exertion
☐Bruise easily, "black and blue"
☐Tendency to anemia
☐Nose bleeds frequently
☐Noises in head, ringing in ears
☐Tension under the breastbone or feeling 'tightness', worse on exertion

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V.

☐Dizzy
☐Dry skin
☐Burning feet
☐Blurred vision
☐Itchy skin on feet
☐Excessive falling hair
☐Frequent skin rashes
☐Bitter, metallic taste in mouth in mornings
☐Bowel movements painful or difficult
☐Sneezing attack
☐Greasy foods upset
☐Stools light – colored
☐Skin peels on foot soles
☐Pain between shoulder blades
☐Use laxatives
☐Stools alternate from soft-watery
☐History of gallbladder attacks or gallstones
☐Feel queasy; headache over eye
☐Dreaming, nightmare type bad dreams
☐Bad breath
☐Milk products cause distress
☐Sensitive hot weather
☐Burning/itchy anus
☐Crave sweats
☐Worries, feels insecure

VI.

☐Loss of taste for meat
☐Lower bowel gas several hours after eating
☐Burning stomach sensation but relieved after eating
☐Coated tongue
☐Pass large amounts of foul smelling gas
☐Indigestion ½-1 hour after eating; may be up to 3-4 hours
☐Mucous colitis or 'irritable bowel'
☐Gas shortly after eating
☐Stomach bloating after eating

VII

☐Insomnia
☐Nervousness
☐Can't gain weight
☐Heart palpitates
☐Eyelids and face twitch
☐Can't work under pressure
☐Intolerance to heat
☐Flush easily
☐Thin, moist skin
☐Increased appetite without weight gain
☐Highly emotional
☐Night sweats
☐Inward trembling
☐Pulse fast at rest
☐Irritable and restless

☐Increase in weight
☐Ringing in ears
☐Dry or scaly skin
☐Hair coarse, falls out
☐Frequency of urination
☐Reduced initiative
☐Decrease in appetite
☐Sleepy during day
☐Constipation
☐Headaches upon arising wear off during day
☐Fatigue easily
☐Sensitive to cold
☐Mental sluggishness
☐Slow pulse, below 65
☐Impaired hearing

☐Failing memory
☐"Splitting" headaches
☐Low blood pressure
☐Low sugar tolerance
☐Increased sex drive

☐Abnormal thirst
☐Sex drive reduced/lacking
☐Women: menstrual disorders
☐Bloating of abdomen
☐Tendency to ulcers or colitis
☐Young girls: lack of menstrual function
☐Weight gain around hips/waist
☐Increased sugar tolerance

☐Dizziness
☐Increased blood pressure
☐Female: Hair growth on face/body
☐Headaches
☐Sugar in urine (not diabetes)
☐Hot flashes
☐Female: masculine tendencies

☐Weakness, dizziness
☐Nails weak, ridges
☐Perspiration increase
☐Swollen ankles
☐Allergies – tendency to asthma
☐Respiratory disorders
☐Chronic fatigue
☐Tendency to hives
☐Bowel disorders
☐Crave salt
☐Weakness after colds, influenza
☐Low blood pressure
☐Arthritic tendencies
☐Poor circulation
☐Brown spots or bronzing of skin
☐Exhaustion–muscular and nervous

Female Only

☐Very easily fatigued
☐Depressed feelings before menses
☐Vaginal discharge
☐Menses scanty or missed
☐Menstruation excessive and prolonged
☐Premenstrual tension
☐Painful breasts
☐Hysterectomy/ovaries removed
☐Acne, worse at menses
☐Painful menses
☐Menstruation too frequently
☐Menopausal hot flashes
☐Long term depression

Males Only

☐Prostate troubles
☐Depression
☐Migrating aches and pains
☐Leg nervousness at night
☐Feeling of incomplete bowel evacuation
☐Urination difficult/dribbling
☐Pain on inside of legs or heels
☐Tire too easily
☐Diminished sex drive
☐Night urination frequent
☐Lack of energy
☐Avoids activity

Detailed Review Of Systems

Cardiovascular

	Present	Past
Poor Circulation	___	___
High Blood Press	___	___
Aortic Aneurysm	___	___
Heart Disease	___	___
Vascular Disease	___	___
Heart Attack	___	___
Chest Pain	___	___
High Cholesterol	___	___
Pace Maker	___	___
Jaw Pain	___	___
Irregular Heart	___	___
Legs Swelling	___	___
Stroke	___	___

Genitourinary

	Present	Past
Kidney Disease	___	___
Lower Side Pain	___	___
Burning Urination	___	___
Frequent Urination	_	___
Blood in Urine	___	___
Kidney Stones	___	___
Bed Wetting	___	___
Prostate Problems	___	___
Rectal Prolapse	___	___

Hematological/Lymphatic

	Present	Past
Hepatitis	___	___
Blood Clots	___	___
Cancer	___	___
Easy Bruising	___	___
Easy Bleeding	___	___
Fever/Chills/Sweat	___	___

Respiratory

	Present	Past
Asthma	___	___
Shortness of Breath	___	___
Upper Resp Infect	___	___
Cold/Flu	___	___
Pneumonia	___	___
Cough/Wheezing	___	___
Emphysema	___	___
RSV	___	___
Tuberculosis	___	___

Ear/Nose/Throat

	Present	Past
Sinus Congestion	___	___
Sinus Infection	___	___
Nosebleed	___	___
Sore Throat	___	___
Difficult Swallow	___	___
Ear Ache	___	___
Ear Infection	___	___
Dizziness	___	___
Hearing Loss	___	___
Bleeding Gums	___	___

Eyes

	Present	Past
Glaucoma	___	___
Double Vision	___	___
Blurred Vision	___	___
Red, Itchy-allergy	___	___

Integumentary

	Present	Past
Eczema	___	___
Rashes	___	___
Psoriasis	___	___
Skin Ulcers	___	___
Skin Disease	___	___
Malignancy	___	___

Allergic / Immunological

	Present	Past
Autoimmune dis.	___	___
Chronic Allergies	___	___
Seasonal Allergies	___	___
Food Allergies	___	___
Environmental All	___	___
Allergy Shots	___	___
Cortisone Use	___	___
HIV/AIDS	___	___
Weak Immune Syst	___	___

Gastrointestinal

	Present	Past
Pancreatitis	___	___
Acid Reflux	___	___
Bowel Problems	___	___
Constipation	___	___
Upset Stomach	___	___
Gas Pains	___	___
Ulcers	___	___
Gallbladder issues	___	___
Liver Problems	___	___
Diarrhea	___	___
Nausea/Vomiting	___	___
Poor Appetite	___	___
Bloody Stools	___	___
Crohn's Disease	___	___
Diverticulitis	___	___
Hiatal Hernia	___	___

Musculoskeletal

	Present	Past
Hip Dislocation	___	___
Torticollis	___	___
Poor Posture	___	___
Neck Pain	___	___
Back Pain	___	___
Arthritis	___	___
Rheumatoid Arth	___	___
Joint Stiffness	___	___
Muscle Weakness	___	___
Osteoporosis	___	___
Broken Bones	___	___
Joint Replacement	___	___
Gout	___	___

Neurological

	Present	Past
Tic Disorder	___	___
Seizures	___	___
Head Injury	___	___
Brain Aneurysm	___	___
Numbness/Tingling	___	___
Pinched Nerves	___	___
Radiating Pain	___	___
Sciatica	___	___
Parkinson's Dis	___	___
Carpal Tunnel	___	___
Balance/Coord	___	___
ADHD/ADD/Sensory Processing Disorder	___	___
Autism/Spectrum	___	___
Migraine	___	___
Bell's Palsy	___	___
Poor Motor Skills	___	___
Epilepsy	___	___
Inflammation	___	___
Trigeminal Neural	___	___
Ear ring/Tinnitus	___	___
Toe Walking	___	___
Sinus Headache	___	___
Tension Headache	___	___
Vertigo/Dizziness	___	___
Sensory Integration	___	___

Endocrine

	Present	Past
Hyperthyroid	___	___
Hypothyroid	___	___
Type 1 Diabetes	___	___
Type 2 Diabetes	___	___
Hair Loss	___	___
Menopausal	___	___
Menstrual Problem	___	___
Hot Flashes	___	___
Endometriosis	___	___
Polycystic Ovarian	___	___
Hashimoto	___	___
Graves Disease	___	___

Psychiatric

	Present	Past
Depression	___	___
Anxiety Disorder	___	___
Unusual Stress	___	___
OCD	___	___
Bipolar Disorder	___	___
S.A.D.	___	___
Mood Swings	___	___
Social Anxiety	___	___
Memory Loss	___	___
Night Tremors	___	___

Constitutional

	Present	Past
Weight Loss/Gain	___	___
Energy Level Low	___	___
Energy Level High	___	___
Difficulty Sleeping	___	___
Chronic Fatigue	___	___
General Malaise	___	___
Compulsive Behavior	___	___
Behavior Issues	___	___
Learning Disability	___	___
Speech Delays	___	___
RLS	___	___
Pregnancy/Fertility	___	___
Obesity	___	___

Stress in our lives can cause vertebral subluxations. Please indicate which of the following stressors you have experienced in your life. Also, please check when you experienced the stress: (C) Child, (T) Teen, (A) Adult.

Physical / Chemical / Emotional Stress			
Trauma at Birth	C	T	A
Slips / Falls	C	T	A
Car Accidents	C	T	A
Poor Posture	C	T	A
Sports Injuries	C	T	A
Work Injuries	C	T	A
Repetitive Stress Injuries	C	T	A
Excessive Computer/TV Time	C	T	A
Sleeping on Belly	C	T	A
Carrying Heavy Child/Purse/Backpack	C	T	A
Sitting on Wallet	C	T	A
Excessive Driving	C	T	A
Excessive Standing	C	T	A
Eating Fast food weekly	C	T	A
Eating Pre-Packaged Food Weekly	C	T	A
Daily Caffeine Intake	C	T	A
Vaccinations/Immunizations	C	T	A
Medication/Antibiotic Use	C	T	A
Smoking/2nd Hand Smoke	C	T	A
Career Stress	C	T	A
Family Stress	C	T	A
Relationship Stress	C	T	A
Pregnancy/Labor	C	T	A
Death of a Loved One	C	T	A
Negative Self Talk/Thoughts	C	T	A
Feeling Pressure	C	T	A
Feeling Fear	C	T	A

Comments:

When a person seeks chiropractic care, it is essential for the individual and chiropractor to be working towards the same objective. It is not our goal or intention to treat or cure any specific symptom or disease. In this office, we provide specific chiropractic adjustments to relieve the body of stress, allowing it to function at its optimal level. Chiropractic is not a substitute for medicine; it instead facilities healing from within. If we find that you are ineligible for care, we will refer you to a proper health care provider.

I have completed the above forms to the best of my ability and understand the above statements. I agree to accept care in the office on this basis.

Signature: _____ Date: _____