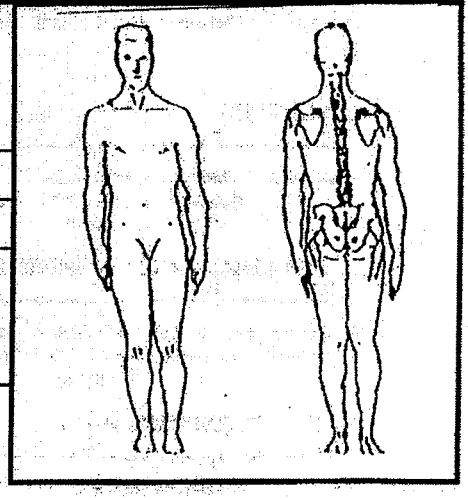
NORTHPORT CHIROPRACTIC - NEW PATIENT HISTORY

TODAY'S DATE: _____ PATIENT NAME: _____

☐ MALE ☐ FEMALE HEIGHT: _____ WEIGHT: _____ D.O.B. _____

MAJOR COMPLAINT: PLEASE BE VERY SPECIFIC

1. PLEASE MARK ON THE DIAGRAM TO THE RIGHT EXACTLY WHERE YOU ARE HURTING.



2. WHAT DO YOU BELIEVE BROUGHT ON THIS PAIN? _____

3. WHEN DID YOUR SYMPTOMS FIRST BEGIN? _____

4. WHAT TYPE OF PAIN ARE YOU HAVING? (PLEASE CIRCLE ALL THAT APPLY)

DULL SHARP ACHING CONSTANT OFF & ON SHOOTING THROBBING BURNING

STABBING PINCHING SQUEEZING OTHER: _____

5. SINCE THE FIRST DAY OF YOUR SYMPTOMS, HAVE THEY: (PLEASE CIRCLE)

GOTTEN WORSE STAYED THE SAME GOTTEN BETTER

6. WHAT ACTIVITIES HAVE YOU NOTICED AGGRAVATE OR INCREASE THE PAIN?

_____

7. DOES THE PAIN RESTRICT YOU FROM PERFORMING THESE ACTIVITIES? ___Y ___N

8. WHAT, IF ANYTHING, HAVE YOU DONE AT HOME TO TREAT YOUR CONDITION? (HEAT, ICE, TYLENOL, ETC.) _____

_____

9. HAVE YOU HAD THIS PROBLEM BEFORE? ___Y ___N IF YES, WHEN? _____

9a. WHAT TREATMENT DID YOU RECEIVE? _____

9b. DID YOU RECEIVE ANY RELIEF FROM THIS TREATMENT? ___Y ___N

9c. WAS THIS TREATMENT PRESCRIBED BY ANOTHER CHIROPRACTOR OR PHYSICIAN? _____

IF SO, PLEASE LIST: NAME PHONE# DATE OF VISIT:

10. HAVE YOU BEEN MEDICALLY DIAGNOSED FOR THIS CONDITION? ___Y ___N

10a. IF SO, PLEASE LIST: _____

11. HAVE YOU EVER HAD SURGERY FOR THIS CONDITION? ___Y ___N

11a. IF YES, PLEASE EXPLAIN: _____

12. HAVE YOU HAD ANY ACCIDENTS OR FALLS THAT MAY HAVE CAUSED YOUR PROBLEM? ___Y ___N

12a. IF YES, PLEASE EXPLAIN: _____

PLEASE LIST ALL PAST SURGERIES OR INJURIES YOU HAVE HAD IN THE PAST REGARDLESS OF THEIR RELATIONSHIP TO YOUR CURRENT COMPLAINT.

_____

_____

_____

_____

_____

PLEASE TURN OVER TO COMPLETE

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

1. PAIN INTENSITY

0	1	2	3	4
No Pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. SLEEPING

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. PERSONAL CARE (WASHING, DRESSING, ETC.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; slow moving	Moderate pain; need assistance	Severe pain; 100% assistance

4. TRAVEL (DRIVING, ETC.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. WORK

0	1	2	3	4
Can do usual work + unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. RECREATION

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. FREQUENCY OF PAIN

0	1	2	3	4
No Pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. LIFTING

0	1	2	3	4
No pain with heavy weight	Increased pain; heavy weight	Increased pain; mod. weight	Increased pain; light weight	Increased pain; any weight

9. WALKING

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain w/ all walking

10. STANDING

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

CHECK OFF ANY SYMPTOMS LISTED BELOW THAT YOU HAVE EXPERIENCED WITHIN THE PAST SIX MONTHS.

____ DIFFICULTY SWALLOWING
____ GALL BLADDER TROUBLE
____ THIGHTNESS IN THROAT
____ PAIN IN SHOULDER
____ NERVES AND NERVOUSNESS
____ MENSTRUAL IRREGULARITY
____ MENSTRUAL CRAMPS & PAIN
____ TIGHTNESS IN SHOULDER
____ PINS & NEEDLES IN ARMS/HANDS
____ PAIN IN LEGS / FEET
____ PINCHED NERVES IN BACK
____ MUSCLE SPASMS IN NECK
____ PINS & NEEDLES IN LEGS/FEET
____ HIGH BLOOD PRESSURE
____ INFLAMMATION OF THROAT
____ TWITCHING OF FACE
____ SHORTNESS OF BREATH

____ GRATING IN NECK
____ HEADACHES
____ STOMACH TROUBLE
____ IRRITABILITY
____ ASTHMA
____ DEPRESSION
____ SLEEPING PROBLEMS
____ RINGING IN EARS
____ ARTHRITIS
____ PAINFUL JOINTS
____ BLURRED VISION
____ NECK PAIN
____ NUMBNESS
____ THYROID TROUBLE
____ LOW BLOOD PRESSURE
____ CANCER

____ SINUS TROUBLE
____ TENSION
____ HAY FEVER
____ HEAD COLDS
____ KIDNEY TROUBLE
____ LOSS OF MEMORY
____ DIABETES
____ FAINTING
____ COLD FEET
____ HEMORRHOIDS
____ CHEST PAINS
____ DIZZINESS
____ ALLERGIES
____ COLD SWEAT
____ SWOLLEN ANKLES
____ SWOLLEN JOINTS

____ HEREDITARY PROBLEMS
____ LOSS OF TASTE
____ ANEMIA
____ HEART ATTACK
____ LIGHT SENSITIVITY
____ TB
____ LOSS OF BALANCE
____ LOSS OF SMELL
____ COLD HANDS
____ LOW BACK PAIN
____ MID BACK PAIN
____ DIARRHEA
____ CONSTIPATION
____ INTESTINAL GAS
____ INDIGESTION
____ FATIGUE

CHECK OFF THE FREQUENCY OF THE FOLLOWING ACTIVITIES.

EXERCISE

____ NONE ____ MODERATE ____ DAILY ____ HEAVY

WORK ACTIVITY

____ SITTING ____ STANDING ____ LIGHT LABOR ____ HEAVY LABOR

HABITS

____ SMOKING
PACKS/ DAY _____

____ ALCOHOL
DRINKS / WEEK _____

____ COFFEE/TEA/CAFFEINE
CUPS / DAY _____

____ HIGH STRESS LEVEL
REASON: _____

PLEASE CONTINUE TO NEXT PAGE