NEW PATIENT INFORMATION

Understanding the health concerns brought you to our office, and their causes, is an important part of providing you effective analysis and proper care. Please take as much time as necessary to answer each of the following questions.

Please be as thorough and complete as possible.

Name:____ Spouse:____________________________

Address:___________________________________ City:__________________ State:_____ Zip:___________

E-mail Address: ____ SS #:______________________________

Hm Phone:____________________ Date of Birth:_____________ ☐ M ☐ S ☐ W ☐ D # of Children: ______

Employer:____ Wk Phone:______________________

What type of work (activities) do you do? ____

Who should we thank for telling you about our office? ____

Please describe in detail the reason(s) for today's visit:

Concern #1:___________________________

Approx Date of Onset: ________________

Degree: ☐ Mild ☐ Moderate ☐ Severe

Concern #2:___________________________

Approx Date of Onset: ________________

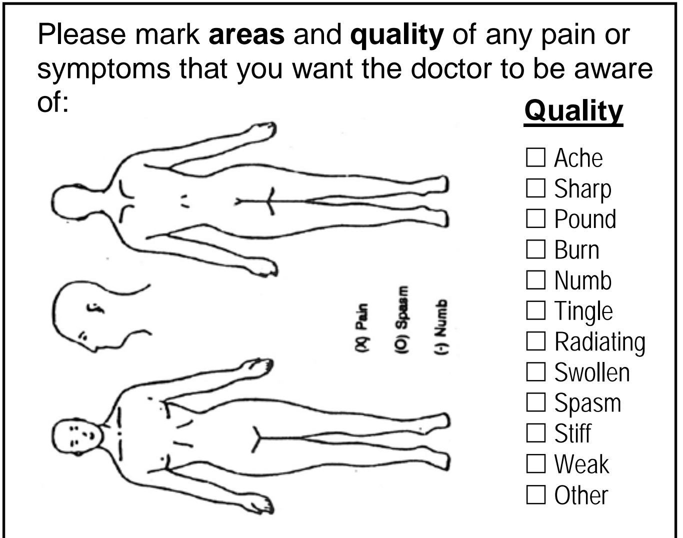
Degree: ☐ Mild ☐ Moderate ☐ Severe

Concern #3:___________________________

Approx Date of Onset: ________________

Degree: ☐ Mild ☐ Moderate ☐ Severe

Please mark **areas** and **quality** of any pain or symptoms that you want the doctor to be aware of:



Quality

☐ Ache
☐ Sharp
☐ Pound
☐ Burn
☐ Numb
☐ Tingle
☐ Radiating
☐ Swollen
☐ Spasm
☐ Stiff
☐ Weak
☐ Other

How often are you aware of your symptoms? ____

What position or activity that makes you feel worse?____

What position or activity provides relief or makes you feel better?_____________________________

Since your complaints began are they trending: ☐ Better ☐ Worse ☐ About the Same

How long have you had these complaints? _______ ☐ Days ☐Weeks ☐ Months ☐ Years

What do you believe has caused your complaints? ☐ Work ☐ Injury ☐ Lifestyle ☐ Other:_______________

Do these complaints interfere with: ☐ Work ☐ Sleep ☐ Sitting ☐ Walking ☐ Other:_______________

Have you ever experienced this problem before? ☐ Yes ☐ No ☐ Many years ago

Have you consulted other doctors for these cocerns? ☐ Yes ☐ No Who:____________________

Have taken any medications for this complaint? ☐ Yes ☐ No What:____________________

In general, how would you rate your <u>overall</u> health & vitality?

(Challenged) ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (Excellent)

How concerned are you about protecting your <u>future</u> health & wellbeing?

(Not) ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (Very)

Nicole Ussery, D.C.

PLEASE COMPLETE OTHER SIDE

YOUR HEALTH HISTORY

Many spinal/health challenges have their origins in the early and the development years of childhood. Please answer the following questions about your health history to the best of your ability. This will give the doctor very important information that will help in the clinical decision making process.

Please check (✓) any health issues that you now or have ever had:

☐ Low Back Pain
☐ Middle Back Pain
☐ Neck Pain
☐ Hip / Leg Pain
☐ Joint Pain
☐ Shoulder /Arm Pain
☐ Headaches
☐ Sleep Disorders
☐ Weak Muscles
☐ Urinary Problems
☐ Weight Loss / Gain

☐ Mood swings
☐ Nervousness
☐ Throat / Voice
☐ Numbness
☐ Dizziness
☐ Seizures
☐ Shaking/Tremors
☐ Coughing or Wheezing
☐ Excessive Thirst
☐ Genital Pain
☐ Heartburn

☐ Eyes / Vision
☐ Ears / Hearing
☐ Sinus Pain / Drainage
☐ Blood Pressure
☐ Cold Hands / Feet
☐ Poor Circulation

☐ Chest Pain
☐ Lungs/Breathing
☐ Dental / TMJ
☐ Nausea
☐ Diarrhea
☐ Constipation

Female Only

☐ Menstrual Problems
☐ Back Pain w/ Period
☐ Birth Control Pills

☐ Breast Lumps
☐ Breast Implants
☐ Breast Pain

CHILDHOOD

	Yes	No	Unsure
Did you have a normal birth?	☐	☐	☐
As a child did you have any serious health issues?	☐	☐	☐
As a child did you have any serious injuries or broken bones?	☐	☐	☐
As a child did you play youth sports?	☐	☐	☐
As a child did you routinely take/use medications?	☐	☐	☐
As a child did you have any major surgeries?	☐	☐	☐
As a child did you ever fall or jump from a height over three feet?	☐	☐	☐
As a child were you involved in any automobile accidents?	☐	☐	☐
As a child were you under regular chiropractic care?	☐	☐	☐

Comments:____

ADULTHOOD

	Yes	No
Do you exercise 3 or more times per week?	☐	☐
Have you had any serious or injuries or broken bones?	☐	☐
have you been involved in any automobile accidents?	☐	☐
As an adult, have you had any major surgeries?	☐	☐
Do you seem to catch colds or the flu easily?	☐	☐
Do you regularly use medications for pain?	☐	☐
Have you missed work in the past year due to illness?	☐	☐
Have any of your co-workers expressed similar health concerns?	☐	☐
Do you have ☐ physical or ☐ mental stress at work?	☐	☐
Do you have ☐ physical or ☐ mental stress at home?	☐	☐

How well do you sleep?	☐ Excellent	☐ Good	☐ Bad	☐ Unsure
How well do you deal with stress?	☐ Excellent	☐ Good	☐ Bad	☐ Unsure
How is your diet?	☐ Excellent	☐ Good	☐ Bad	☐ Unsure
How are your energy levels?	☐ Excellent	☐ Good	☐ Bad	☐ Unsure
How do you think your posture is?	☐ Excellent	☐ Good	☐ Bad	☐ Unsure

I understand that my care in this office involves the making of judgements that are based upon the facts known by the doctor. Therfore, the above information is true and complete to the best of my knowledge.

X:_______________________________________ ____/____/______

Patient's Signature *Date*

Nicole Ussery, D.C.