Park Bench Chiropractic

New Patient

Date: _____

Name: _____ D.O.B.:_____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Cell: _____

Email address: _____ ☐ check box to join email mailing list

Best way to contact you: ☐ Home ☐ Cell ☐ Email ☐ Don't call me, I'll call you

Who can we thank for referring you? _____
Primary Care Physician's name: _____

Employer(s): _____ Time at job: _____
Occupation, including description of work done: _____
_____

Is this health concern associated with a work injury? ☐ Yes ☐ No

If so, have you reported this to your employer? ☐ Yes ☐ No

Is this health concern associated with an automobile accident? ☐ Yes ☐ No
Claim #:_____ Adjuster's Name:_____ Phone: _____

If so, have you reported this to your insurer? ☐ Yes ☐ No

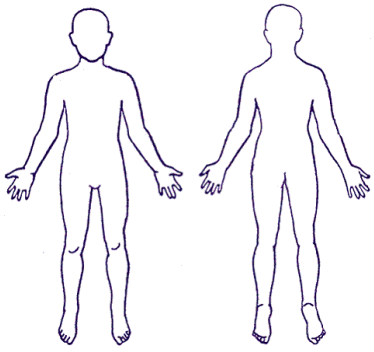
Will this care be covered by insurance (including automobile insurance)? ☐ Yes ☐ No
Insurer: _____ Policy #: _____
Policy Holder:_____ DOB: _____ Relationship to you: _____

Have you ever been to a chiropractor before? ☐ Yes ☐ No

If so, how was your experience? ☐ Good ☐ Bad ☐ Indifferent ☐ Other:_____

What health concern brings you to our office? _____

On a scale of 1 – 10 how irritating is this to you? 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10



On the image to the left please show where your problem is by putting a letter on the place that's bothering you:

N = numb
T = tingling
P = pain
B = burning
H = heavy
S = stabbing
X = _____

Have you ever seen any other health care provider for **this condition**? ☐ Yes ☐ No

If so, please explain: _____

Past Medical History

Past Injuries:

Type of Injury	Date

Treatments Received:

Type	How Many	Dates (Approx)
Epidural		
Steroid Injection (ie Cortisone)		
Physical Therapy		
Surgery		
Other: _____		
Other: _____		

Did any of those treatments help? ☐ Yes ☐ No _____

Past Surgeries or Hospitalizations:

Type of Surgery/Reason for Hospitalization	Date

Medication or Supplement Use:

Name (mg/day)	Name (mg/day)

*Please use the other side of this paper for additional medications or supplements

Have you recently experienced any of the following problems?

☐ Dizziness ☐ Hearing or Vision Trouble ☐ Numbness or Tingling
☐ Confusion or Irritability ☐ Severe Headache ☐ Slurred Speech

Do you suffer from any of the following?

Previously	Currently		Previously	Currently		Previously	Currently	
☐	☐	Diabetes	☐	☐	Asthma	☐	☐	Anxiety
☐	☐	Skin Rashes	☐	☐	Gastrointestinal Problems	☐	☐	Cancer/Tumor
☐	☐	Fatigue	☐	☐	Depression	☐	☐	Shakes/Tremors
☐	☐	High Cholesterol	☐	☐	Stroke	☐	☐	Heart Disease
☐	☐	Constipation	☐	☐	Heartburn	☐	☐	Ringing Ears
☐	☐	High Blood Pressure	☐	☐	Low Blood Pressure	☐	☐	"Hot Flashes"
☐	☐	Arthritis	☐	☐	Headaches	☐	☐	Cold Extremities
☐	☐	OTHER: _____						

Family Medical History

Please indicate if any of your family members have been affected by any of these conditions:

☐	Heart Disease	☐	Diabetes	☐	Arthritis
☐	Stroke	☐	Cancer	☐	Gastrointestinal Problems
☐	High Blood Pressure	☐	Low Blood Pressure	☐	Headaches
☐	Back Pain	☐	Chest Pain	☐	Back or Neck Surgery
☐	Please List Any Additional Conditions: _____				

Lifestyle Questions

Answers in this section are confidential and will not be shared with anybody, including your health insurer. This information is for our information only.

Average hours of uninterrupted sleep per night: _____ If less than 6-8 hours, why? _____

Do you smoke? ☐ Yes ☐ No If so, how many packs per day? _____

Do you drink alcohol? ☐ Yes ☐ No If so, how many drinks per week? _____

Do you exercise regularly? ☐ Yes ☐ No

How is your diet? ☐ Healthy ☐ Not so healthy