Feel Awesome ***New Patient Questionnaire***

Patient Information

Name_____ **Date**_____
Location Address _____**City**_____ **State**_____ **Zip**_____
Mailing Address _____**City**_____ **State**_____ **Zip**_____
❑**Male** ❑**Female** ❑**Married** ❑**Single** ❑**Widowed** ❑**Divorced** ❑**Separated**
Birthdate_____ **Home Phone**_____ **Cell**_____
E-mail Address_____**Occupation**_____ **#Years**_____
Emergency Contact_____ **Phone** _____ **Relation**_____
Whom may we thank for referring you to us? _____
How did you hear about us?_____
Name of local primary Physician_____ **May we contact them?**_____

Symptoms and Previous Care

Main Complaint_____ **How Bad?**_____ **How Often?**_____
When & how did it start?_____ **Getting Worse?**_____ **Getting Better?**_____
What activity(s) bothers it the most? _____
When is it at its best?_____ **When is it at its worst?**_____
Rate the pain - (circle one - 0 is pain free - 10 is unbearable pain) 0 1 2 3 4 5 6 7 8 9 10
Other Chiropractors?_____ **Positive Experience?**_____
Other type of physician or therapist?_____ **Positive Experience?**_____
Other Complaint(s) _____

Health History - *Please circle all that apply*

AIDS/ HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthritis	Asthma	Bleeding
Breast Lump	Bronchitis	Bulimia	Cancer	Cataracts	Chicken pox	Depression	Diabetes
Emphysema	Epilepsy	Fractures	Glaucoma	Goiter	Gonorrhea	Gout	Heart dx
Hepatitis	Hernia	Herniated disc	Herpes	High Cholesterol	Kidney dx	Liver dx	Measles
Migraines	Miscarriage	Mono	M. S.	Mumps	Osteoporosis	Parkinson's	Polio
Pacemaker	Pneumonia	Prostate	Prosthesis	Implants	Rheumatoid	Stroke	Thyroid
Tonsillitis	Tuberculosis	Tumors	Typhoid	Ulcers	V. D.	Whooping Cough	
Chronic Fatigue	High Blood Pressure		Fibromyalgia	Other_____			

Surgeries / Accidents and Dates? _____
List ALL Medications you are currently taking _____
_____
What kind of exercise do you do? _____
What supplements do you take?_____
How much do you smoke per day?_____ **Drinks per week?** _____ **How many children?**____

How important is your health to you? (circle one)	**Extremely**	**Very**	**Somewhat**	**Minimally**
Rate your physical health: (circle one)	**Excellent**	**Good**	**Fair**	**Poor**
Change in physical health lately: (circle one)	**Improving**	**Not Changing**		**Worsening**
Rate your mental-emotional health: (circle one)	**Excellent**	**Good**	**Fair**	**Poor**
Change in mental-emotional health lately: (circle one)	**Improving**	**Not Changing**		**Worsening**

Goals of Care

What does being truly healthy mean to you? _____
What do you want to be able to do that you can't do right now? _____
_____
Any other health goals, information, thoughts or concerns?_____
_____