Harmony Chiropractic Arts

New Patient Questionnaire

Date:_____

Name:_____ Home Phone: (____)_____ Cell Phone: (____)_____

Address:_____ City:_____ State:_____ Zip:_____

Occupation:_____ Business Phone: (____)_____ E-mail:_____

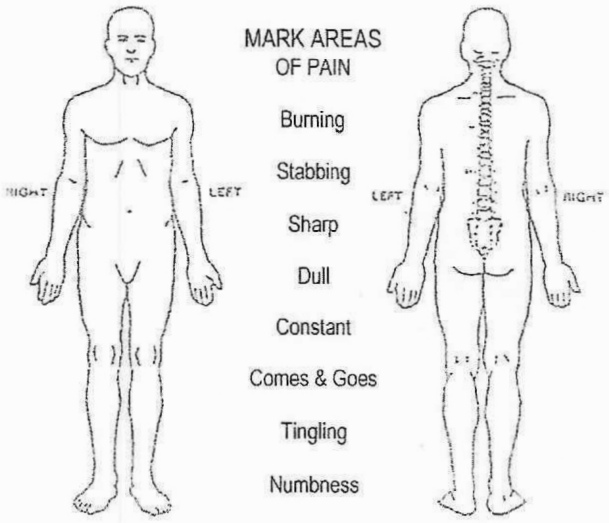
Company Address:_____

Date of Birth:_____ Male:_____ Female:____ Social Security #:_____-____-_____

Do you have health insurance? Y N Insurance Company:_____

Who referred you to our office?:_____

Please mark the areas of pain or injury on the illustrations below:



Date of injury:_____ Time:_____

Where did it happen?_____

What happened? _____

List all out-of-the-ordinary pains, discomforts, or other symptoms you have experienced as a result of this injury:_____

_____

What have you done to try to relieve your symptoms?:_____

_____

It is worse when I:_____

Have others in your family had a similar condition?_____

Have you been to a chiropractor before?_____

Dr._____ Dates:_____

Your physical health...past to present

BIRTH

- Were there any factors present at the time prior to your birth that may have affected your mother's pregnancy or delivery of you?

  Physical/Environmental_____

  Emotional_____

  Chemical_____

- Where were you born (city & hospital, home)?_____
- Was your delivery: _____drug induced? _____"C" section? _____breech? _____prolonged?

  _____cord around neck? _____forceps or suction?

CHILDHOOD

- List all falls you have had and using a severity rating of 1-5.

  _____ _____

  _____ _____

- Were you ever knocked unconscious? _____ Yes _____ No

  _____

- Have you ever broken any bones? _____ Yes _____ No

  _____

- Have you ever used crutches, a walker or a cane? _____ Yes _____ No

  _____

- Have you ever had any impacts, falls or jolts that you feel specifically may have injured your spine? _____ Yes _____ No

  _____

ADULTHOOD

- Have you had extensive dental or orthodontal work performed? _____ Yes _____ No

  _____

- Were you or are you active in any sports? _____ Yes _____ No

  Have you been hurt in any of these activities? _____ Yes _____ No

- Do you perform any of the following activities for more than an hour at a time?

  ☐ Reading ☐ Watching television ☐ Sitting in front of a computer

  ☐ Gardening ☐ Other_____

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ACCIDENTS

- Have you ever been in a motor vehicle accident whether as a passenger or a driver, even if you do not think that you were hurt? _____ Yes _____ No

  Please list the approximate dates and use the severity rating of 1-5 (1= mild, 5 = traumatic)

  _____

  _____

- Have you ever been involved in an accident on the following?

  ☐ Bicycle ☐ Moped ☐ Motorcycle ☐ Train ☐ Airplane ☐ Bus ☐ Other_____

  _____

MEDICAL TRAUMA

- Have you ever been hospitalized or had surgery? _____ Yes _____ No

  _____

  _____

  _____

- Are you currently taking any drugs (prescription or over-the-counter or recreational) regularly? _____ Yes _____ No

  _____

  _____

- Were you previously taking any medications regularly? _____ Yes _____ No

  _____

- Have you ever been: ☐ Immunized ☐ Transfused

DIET

- Please check the type of foods you consume on a weekly basis:

☐ Alcohol	☐ Eggs	☐ Beef
☐ Coffee	☐ Cooked, can vegetables	☐ Poultry
☐ Tobacco	☐ Raw vegetables	☐ Fish
☐ Artificial sweeteners	☐ Fruit	☐ Seafood
☐ Soda	☐ Whole grains	☐ Weight control diet
☐ Diet food	☐ Dairy	☐ Fasting
☐ Refined sugars	☐ Fried foods	☐ Organic foods

- The type of diet I usually follow could be classified as: _____
- What is your source of drinking water? _____
- What is your daily consumption of water? _____

PHYSICAL/MENTAL/EMOTIONAL

- What is the current level of physical stress in your daily life?
  ☐ High ☐ Moderate ☐ Low
- What is your current level of mental-emotional stress?
  ☐ High ☐ Moderate ☐ Low
- How do you grade your level of spiritual well being?
  ☐ High ☐ Moderate ☐ Low
- Please list these emotional or mental stress factors using the rating scale below (indicate past or present):

Childhood stress	1	2	3	4	5
School stress	1	2	3	4	5
Play, or recreation	1	2	3	4	5
Present family stress	1	2	3	4	5
Personal relationships	1	2	3	4	5
Stress of being sick	1	2	3	4	5
Work related stress	1	2	3	4	5
Stress of commuting	1	2	3	4	5
Loss of loved one	1	2	3	4	5
Change in lifestyle	1	2	3	4	5
Change in vocation	1	2	3	4	5

- Please tell us what your reasons or expectations are for coming to Harmony Chiropractic Arts for care:

_____

_____

_____

_____

- Is there anything you want the doctor to know about your health?

_____

_____

_____

- Are you interested in the following areas of personal development:
  - ☐ Weight loss
  - ☐ Weight gain
  - ☐ Stretching/exercise programs
  - ☐ Mental/emotional stress management
  - ☐ Indepth nutritional analysis
  - ☐ Detoxification programs
  - ☐ Eating guidelines
  - ☐ Lifestyle management
  - ☐ Pre and post natal wellness care
  - ☐ Wellness care for children
  - ☐ Athletic/academic support and development
- Thank you for taking the time to let us know exactly how you are...

Let the healing begin.

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