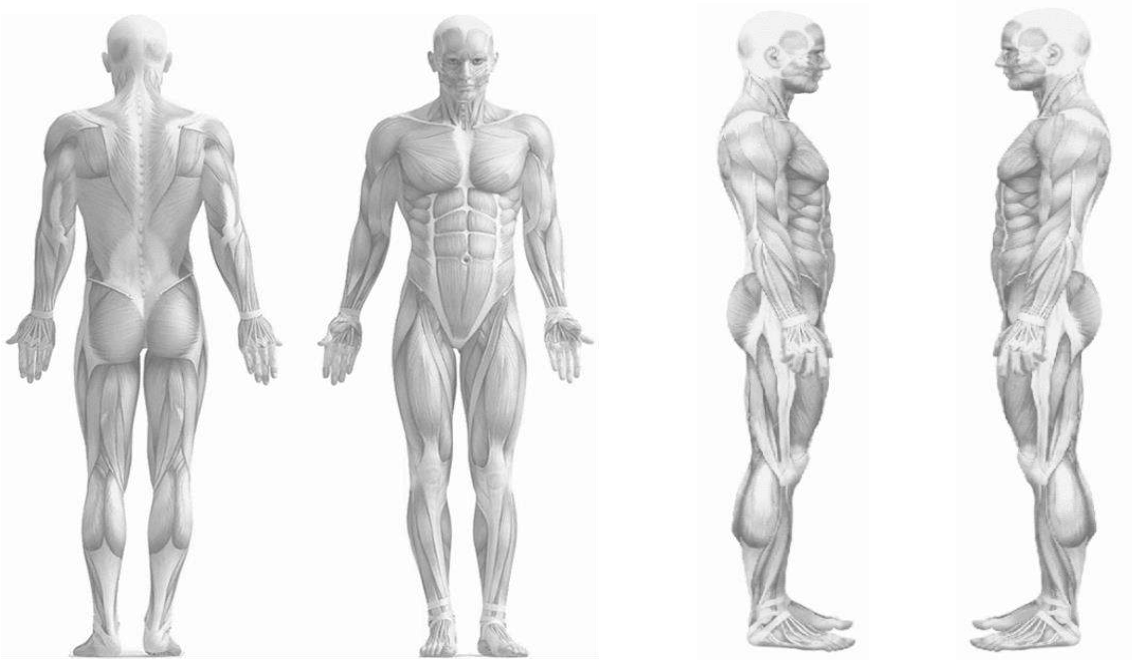
REACTIVATE Chiropractic & Rehab

NEW PATIENT HISTORY

Date:

Name		☐Male ☐Female	**DOB**	/ /			
Race/Ethnic	☐White/Caucasian ☐Black/African Amer ☐Hispanic/Latin ☐Native American ☐Asian ☐Pacific/Hawaiian						
Address		**City**		**State**		**Zip**	
Contact	**Phone**		**Email**				
Found us on	☐Google ☐Internet ☐Ad: ☐Referral: ☐Other:						
Emergency Contact Name		**Phone**		**Relation**			

Please use the guide to mark your area(s) of complaints



A = Ache

V = Sharp

O = Throb

T = Tight/Tension

* = Shooting

S = Stabbing

E = Electric

B = Burning

//= Tingling/Numb

X = Other_____

Please separate your complaints and describe them individually below. List most severe complaint first.

Complaint # 1	Side/Location/Description	When did it start?	What caused it (if known)?

Complaint # 2	Side/Location/Description	When did it start?	What caused it (if known)?

Complaint # 3	Side/Location/Description	When did it start?	What caused it (if known)?

Other Complaints	Description: Location of pain, How did it happen, Other relevant Information

Patient Name: **Date:**

CURRENT MEDICAL HISTORY

Primary Care Doctor_____ Clinic_____ ☐MD ☐DO ☐PA ☐NP
Other Doctor _____ Clinic_____ Specialty_____
Other Doctor _____ Clinic_____ Specialty_____
Which of these Doctors are aware of your current complaint(s)?_____
Have you seen a Chiropractor before?_____

Current Meds ☐List provided	Allergies ☐List provided	Related Diagnoses/Conditions
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST MEDICAL HISTORY

When was your last physical exam? Date_____ Doctor _____

Surgeries and Injuries

Date	Description
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

CONDITION	Father	Mother	Sister	Brother	Grandfather	Grandmother
Anxiety	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Low Blood Pressure	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Neck Pain	☐	☐	☐	☐	☐	☐
Back Pain	☐	☐	☐	☐	☐	☐
Headaches/Migraines	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐
Scoliosis	☐	☐	☐	☐	☐	☐
Disc Problems	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Kidney Problems	☐	☐	☐	☐	☐	☐
Liver Problems	☐	☐	☐	☐	☐	☐
Other (list beside relative)	☐	☐	☐	☐	☐	☐
Other (list beside relative)	☐	☐	☐	☐	☐	☐
Other (list beside relative)	☐	☐	☐	☐	☐	☐
Cause of Death If Deceased (Age at Death)						

Patient Name: **Date:**

SOCIAL HISTORY

Employment: ☐Full-time ☐Part-time ☐Student ☐Retired ☐Unemployed ☐Disabled ☐Other _____
Occupation_____ Job Activities_____

Cultural/Religious: customs/beliefs we need to be aware of?_____

Social / Health Habits:

- **Nicotine**: ☐Now ☐In Past ☐Tobacco ☐Smokeless ☐Vape How much? _____
- **Recreational Drugs**: ☐Now ☐In Past What Drugs?_____
- **Alcohol:** ☐Now ☐In Past ☐ Alcoholic days/week____ How much?_____
- **Caffeine:** ☐Coffee ☐Energy Drinks ☐Soda ☐Other_____ How much?_____
- **Exercise:** ☐Yes ☐No Type_____ days/week_____ minutes_____
- **Sleep Quality:** ☐Great ☐Good ☐Okay ☐Poor ☐Terrible Hours per night_____
- **Stress:** ☐Extreme ☐High ☐Moderate ☐Low ☐None

General Health Status: ☐Excellent ☐Good ☐Fair ☐Poor

Living Environment: ☐Alone ☐With Spouse ☐With Children ☐Other _____

Language: Primary _____ Other _____ Need a Translator? ☐Yes ☐ No

Disabilities: ☐Vision ☐Hearing ☐Reading ☐Writing ☐Other _____

REVIEW OF SYSTEMS

Musculoskeletal
☐ Neck Pain
☐ Mid Back Pain
☐ Low Back Pain
☐ Shoulder/Arm Pain
☐ Hand/Wrist Pain
☐ Hip/Leg Pain
☐ Foot/Ankle Pain
☐ Jaw Pain
☐ Swollen Joints
☐ Stiff Joints
☐ Painful Joints
☐ Sore Muscles
☐ Weak Muscles

EENT
☐ Vision Problems
☐ Eye Irritation
☐ Cataracts
☐ Eye Strain
☐ Ear Pain
☐ Hearing Problems
☐ Ringing in Ears
☐ Ear Discharge
☐ Sinus Pain
☐ Nose Pain
☐ Nose Bleeds
☐ Nose Discharge
☐ Difficulty Breathing
☐ Sore Throat

Neurological
☐ Headaches/Migraines
☐ Numbness/Tingling
☐ Paralysis
☐ Dizziness/Vertigo
☐ Fainting
☐ Muscle Twitching
☐ Tremors
☐ Seizures
☐ Confusion
☐ Forgetfulness
☐ Depression
☐ Insomnia
☐ Balance/Walking Issues

Gastrointestinal
☐ Poor Appetite
☐ Excessive Hunger
☐ Excessive Thirst
☐ Difficulty Chewing
☐ Difficulty Swallowing
☐ Blood in Stool
☐ Nausea
☐ Vomiting
☐ Stomach Cramps
☐ Diarrhea
☐ Constipation
☐ Bloating
☐ Gum Problems

Constitutional
☐ Weight Gain/Loss
☐ Fever
☐ Fatigue

Genitourinary
☐ Bladder Trouble
☐ Excessive Urination
☐ Scanty Urination
☐ Painful Urination
☐ Discolored Urine

Cardiovascular/Pulmonary
☐ Chest Pain
☐ Difficulty Breathing
☐ Cough
☐ Heart Problems
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Varicose Veins
☐ Swelling of Extremities

Skin
☐ Rash
☐ Itching
☐ Color Change
☐ Strange Mole(s)
☐ Sores
☐ Blemishes
☐ Acne
☐ Nail Problems
☐ Hair loss
☐ Dry Skin

Female Only
☐ Painful/Irregular Periods
☐ Vaginal Pain
☐ Vaginal Discharge
☐ Breast Pain
☐ Breast Lumps
☐ Pregnant
☐ Last Period_____

I certify that the information provided on this form (3 pages) is true and complete to the best of my knowledge and authorize this office to evaluate, diagnose and treat my complaints based upon the information I have provided.

_____ _____
Patient/Guardian Signature **Date**