Newbold Chiropractic

Phone 650-726-3300

ABOUT YOU

Today's Date: _____ Name: _____

Name you prefer to be called: _____ Birthday: _____ Age: _____

Social Security Number: _____

Mailing Address: _____

Home Phone: _____ Work: _____ Cell: _____

Email address: _____

Occupation: _____

Marital Status: _____Spouse's Name: _____

Who is your medical doctor? _____ Phone:_____

In the event of an emergency whom should we contact? _____

Relation: _____Phone _____

How did you hear about us? _____

REASON FOR VISIT

If your injury was the result of a work or auto injury, you will need to fill out additional paperwork. Please inform the receptionist.

The reason for this visit is a result of (Please circle): work sports auto trauma chronic

Explain the reason for your visit: _____

_____

When did the condition begin? _____Is this condition getting worse? ☐Yes ☐No

Does the condition come and go or is it constant? _____

Is this condition interfering with your (Please circle): work sleep daily routine

If so, please explain: _____

Have you had this or similar conditions in the past? ☐Yes ☐No

If so, please explain: _____

Have you ever been treated by a Medical Physician for this condition? ☐Yes ☐No

If so, where? _____

Have you ever been treated by a Chiropractor for this or any other reason? ☐Yes ☐No

If so, please explain: _____

_____

Do you have recent x-rays? ☐Yes ☐No If so, where were they taken? _____

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HEALTH HISTORY

Your height _____ weight _____

Are you taking any of the following medications? (please circle) pain killers (includes aspirin), muscle relaxants, stimulants, blood thinners, tranquilizers, insulin, other (please list)

_____

Have you ever had any of the following medical conditions/diseases?

Y N Heart attack/stroke	Y N Heart Surg./pacemaker	Y N Heart murmur
Y N Congenital heart defect	Y N Mitral valve prolapse	Y N Artificial valves
Y N Alcohol/drug abuse	Y N Venereal disease	Y N Hepatitis
Y N HIV +/Aids	Y N Shingles	Y N Cancer
Y N Frequent neck pain	Y N Emphysema/glaucoma	Y N Anemia
Y N High/low blood pressure	Y N Psychiatric problems	Y N Rheumatic fever
Y N Severe/frequent headaches	Y N Kidney problems	Y N Ulcers/colitis
Y N Fainting/seizures/epilepsy	Y N Sinus problems	Y N Asthma
Y N Diabetes/tuberculosis	Y N Difficulty breathing	Y N Chemotherapy
Y N Lower back problems	Y N Artificial bones/joints	Y N Arthritis

Please list any other serious medical conditions you have or have ever had: _____

_____

List previous surgeries/treatments with dates: _____

_____

Serious accidents with dates: _____

Family Health History _____

Do you smoke? ☐Yes ☐No If so, how much? _____ How long have you smoked? _____

Are you wearing: ☐Heel lifts ☐Sole lifts ☐Inner soles ☐Arch supports

What is the age of your mattress?_____ Is it comfortable? ☐Yes ☐No

FOR WOMEN: Are you taking birth control? ☐Yes ☐No

Are you pregnant? ☐Yes ☐No What term? _____ Nursing? ☐Yes ☐No

INSURANCE INFORMATION

Insurance Company: _____ Insured's SSN: _____

Group Number (Plan or Policy Number):_____

Insured's Name: _____ Relationship to Patient: _____

Insured's Date of Birth: _____Insured's Employer: _____

☐ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. Please remember you are ultimately responsible for your account.

Signature_____ Date _____

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Name_____ **Date**_____

CURRENT MEDICAL COMPLAINTS

BACK PAIN:

1. Currently I have pain in my :	( ) low back	( ) mid back	( ) upper back
2. My pain began:	( ) gradually	( ) suddenly	
3. I have pain:	( ) sometimes	( ) all of the time	
4. My pain goes into my:	( ) right leg	( ) left leg	( ) both
5. I have tingling and/or numbness in my:	( ) right leg	( ) left leg	( ) both
6. My pain is worse when I:			
Cough or sneeze	( ) Yes	( ) No	
Sit	( ) Yes	( ) No	
Bend	( )Yes	( ) No	
Walk	( ) Yes	( ) No	
Lift	( ) Yes	( ) No	
Push	( ) Yes	( ) No	
Pull	( ) Yes	( ) No	
7. My back is worse with sexual activity	( ) Yes	( ) No	
8. My pain wakes me up during the night	( ) Yes	( ) No	
9. Changes in the weather affect my pain	( )Yes	( ) No	

NECK PAIN:

1. My neck pain began:	( ) gradually	( ) suddenly	
2. I have pain:	( ) sometimes	( ) all of the time	
3. My pain goes into my:	( ) right arm	( ) left arm	( ) both
4. I have tingling and/or numbness in my:	( ) right arm	( ) left arm	( ) both
5. My pain is worse when I:			
Cough or sneeze	( )Yes	( ) No	
Bend forward	( ) Yes	( ) No	
Lift	( ) Yes	( ) No	
Push	( ) Yes	( ) No	
Pull	( ) Yes	( ) No	
Turn my head	( ) Yes	( ) No	
6. My pain wakes me up during the night	( ) Yes	( ) No	
7. Changes in the weather affect my pain	( ) Yes	( )No	
8. I have neck stiffness	( )Yes	( ) No	
9. I have headaches	( ) Yes	( )No	
10. If I do get headaches, they occur	( ) sometimes	( ) all the time	

OTHER PAIN: Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire, or list any additional comments you wish to make regarding your conditions: _____

_____

_____

_____

_____