

PLEASE PRINT OUT THESE TWO PAGES, FILL OUT AND BRING IN TO YOUR FIRST APPOINTMENT

Carlson Chiropractic

New Patient Form

Print Name _____ Email _____

Street Address _____ City _____

State _____ Zip _____ Date of Birth _____ SSN _____

Home Phone _____ Work _____ Cell _____

Please Circle: Male , Female | Right Handed , Left Handed | Married , Single

Health History

Please provide reason for seeking chiropractic care: _____

Describe any health problems, including how long you've had them: _____

Are you under the care of any other doctor? Yes No

If Yes, list please list the conditions you are being treated for:

List any current Medications: _____

List any past surgeries & dates: _____

List any past accidents & dates: _____

List any x-rays you've had in the past 2 years :

Personal & Family History

Your Occupation: _____ Work Duties _____

Spouse's health status _____

Children's ages and health status: _____

Chiropractic History

Have you been to a chiropractor before? Yes ___ No ___ Doctor's Name: _____

Date of last visit: _____ Reason for care: _____

Last day of chiropractic x-rays: _____ Length of care: _____

Are other family members under chiropractic care? Yes No Who? _____

Where did you hear about our office?

Who referred you?

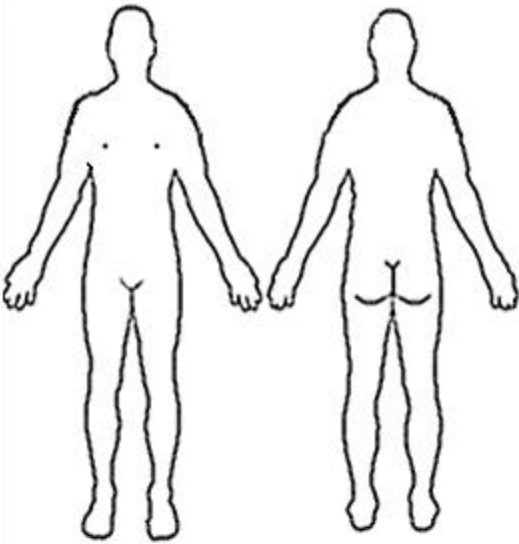
Females

Is there a possibility that you are pregnant? Yes No

Please Check below if you have had the following or have suffered from any of the following:

Condition or problem	Constant or Frequently	Sometimes or Occasionally
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arm/Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>
Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>
Leg/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>
Disc Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Other joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Joint Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>
Ear Aches	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
Female Problems	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Digestive Problems	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>
Skin Conditions	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Please circle the area where your major problem is and describe that problem.



Please tell us any other medical information we might need to know to better care for you:

Thank you for helping us care for you by being thorough with this form.

Patient Signature

Date