New Patient Self-Assessment

Winchester Chiropractic Center, LLC

On Staff Chiropractic Physicians, Winchester Hospital

STAFF USE ONLY

Blood Pressure _____/_____
□ Left Arm □ Right Arm
□Seated □Supine □Standing
Pulse _____ **Resp.**_____**Temp**_____°F

TODAY'S DATE: _____/_____/_____ DOB: _____/_____/_____ AGE_____

PATIENT'S NAME:_____ NICKNAME:_____

PHONE NUMBER:_____

HOME ADDRESS: _____

HEALTH INSURANCE:_____ MEMBER ID#_____

EMAIL ADDDRESS:_____

WHO TOLD YOU ABOUT OUR OFFICE:_____

PRIMARY CARE PHYSICIAN:_____

PRIMARY CARE PHYSICIAN ADDRESS:_____

OCCUPATION: _____

PLACE OF EMPLOYMENT :_____

EMERGENCY CONTACT:_____

SEX: MALE/FEMALE HEIGHT___/___ WEIGHT_____

DOMINANT HAND: L☐ R☐ AMBIDEXTROUS☐

ETHNICITY

☐ I DO NOT WISH TO PROVIDE THIS INFORMATION

☐ HISPANIC OR LATINO

☐ NON-HISPANIC OR NON-LATINO

☐ OTHER _____

RACE

☐ I DO NOT WISH TO PROVIDE THIS INFORMATION

☐ WHITE

☐ BLACK OR AFRICAN AMERICAN

☐ AMERICAN INDIAN OR ALASKA NATIVE

☐ ASIAN

☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

☐ OTHER_____

HEAD, NECK, BACK, EXTREMITIES Check symptoms you currently have or have had in the past year

HEAD	Left	Right
☐ Headaches	☐L	☐R
☐ Migraines	☐L	☐R
☐ Face pain	☐L	☐R
☐ Jaw pain	☐L	☐R
NECK		
☐ Pain in neck	☐L	☐R
☐ Neck stiffness	☐L	☐R
☐ Neck weakness	☐L	☐R
☐ Grinding sounds in neck	☐L	☐R
☐ Tingling in the neck	☐L	☐R
☐ Neck feels out of place	☐L	☐R
MIDBACK		
☐ Midback pain	☐L	☐R
☐ Midback stiffness	☐L	☐R
☐ Pain between shoulder blades	☐L	☐R
☐ Muscle spasms in midback	☐L	☐R
☐Midback feels out of place	☐L	☐R
LOWER BACK		
☐ Pain in lower back	☐L	☐R
☐ Lower back stiffness	☐L	☐R
☐ Muscle spasms in lower back	☐L	☐R
☐ Lower back feels out of place	☐L	☐R

ARMS & HANDS	Left	Right
☐ Pain in upper arm	☐L	☐R
☐ Pain in elbow	☐L	☐R
☐ Pain in forearm	☐L	☐R
☐ Pain in hand/fingers	☐L	☐R
☐ Pins/needles feeling in arm	☐L	☐R
☐ Pins/needles feeling in finger	☐L	☐R
☐ Numbness in arm	☐L	☐R
☐ Numbness in hand/fingers	☐L	☐R
☐ Weak arm/hand	☐L	☐R
HIPS, LEGS & FEET		
☐ Pain in buttocks	☐L	☐R
☐ Pain in hip joint	☐L	☐R
☐ Pain down leg	☐L	☐R
☐ Pain in knee	☐L	☐R
☐ Pain in ankle	☐L	☐R
☐ Pain in foot	☐L	☐R
☐ Pain in toes	☐L	☐R
☐ Pins/needles in leg	☐L	☐R
☐ Pins/needles in toes	☐L	☐R
☐ Numbness in leg	☐L	☐R
☐ Numbness in foot/toes	☐L	☐R
☐ Weakness of leg	☐L	☐R
☐ Weakness of knee	☐L	☐R

HEAD, NECK, BACK, EXTREMITIES, CONTINUED….

SHOULDERS			HIPS, LEGS & FEET CONTINUED		
☐ Pain in shoulder	☐L	☐R	☐ Leg cramps	☐L	☐R
☐ Pain across tops of shoulders	☐L	☐R	☐ Cold feet	☐L	☐R
☐ Can't raise arm	☐L	☐R			
☐ Above shoulder level	☐L	☐R	**OTHER SYMPTOMS:**		
☐ Overhead	☐L	☐R			
☐ Tingling in shoulder	☐L	☐R			
☐ Numbness in shoulder	☐L	☐R			

HISTORY OF CURRENT COMPLAINT

REASON FOR TODAY'S VISIT

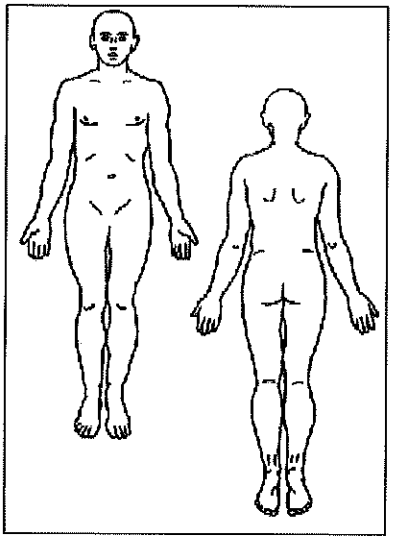
☐Work Injury ☐Car Accident ☐Headache ☐Neck Pain ☐Mid-Back Pain ☐Low Back Pain

☐Other_____

_____

Date Problem Began____/____/_____ **How Problem Began**_____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



How do you feel today? **Please circle a number that best describes your pain.**

0 1 2 3 4 5 6 7 8 9 10

No pain — Moderate pain — Worst pain imaginable

How often are your symptoms present

(Occasional) ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% (Constant)

In general my overall health right now is

☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

HAVE YOU HAD SPINAL XRAYS, MRI, AND CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐No ☐Yes

If yes, date(s) taken: _____ Location if known:_____

What areas where taken:_____

GENERAL SYMPTOMS Check symptoms you currently have or have had in the past year.

GENERAL

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Anorexia/Bulimia
- ☐ Arthritis
- ☐ Bleeding Disorders
- ☐ Cancer/Tumors
- ☐ Chemical Dependency
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting or Seizures
- ☐ Fibromyalgia
- ☐ Forgetfulness
- ☐ Gout
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Multiple Sclerosis
- ☐ Nervousness
- ☐ Night Sweats
- ☐ Osteoporosis
- ☐ Paralysis
- ☐ Psychiatric Care
- ☐ Stroke
- ☐ Tiredness
- ☐ Thyroid Problems
- ☐ Weight Change (dramatic)

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Low Blood Pressure
- ☐ Pacemaker
- ☐ Poor Circulation
- ☐ Swelling of Ankles
- ☐ Varicose Veins

EYE, EAR, NOSE, THROAT

- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Double Vision
- ☐ Floaters/Haloes
- ☐ Glaucoma
- ☐ Earache
- ☐ Hearing Loss
- ☐ Ringing in ears
- ☐ Vertigo (dizziness)
- ☐ Allergies/Hay fever
- ☐ Nasal Drip
- ☐ Nosebleeds
- ☐ Sinus Problems
- ☐ Bleeding Gums
- ☐ Chronic Cough
- ☐ Difficulty Swallowing
- ☐ Slurred Speech
- ☐ Throat Hoarseness

RESPIRATORY

- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Mono
- ☐ Emphysema
- ☐ COPD
- ☐ Shortness of Breath

SKIN

- ☐ Bruises Easily
- ☐ Changes in Moles
- ☐ Eczema/Psoriasis
- ☐ Hives/Rash
- ☐ Itching
- ☐ Skin Cancer
- ☐ Sores not healing

GASTRO-INTESTIONAL

- ☐ Poor Appetite
- ☐ Black/Bloody Stool
- ☐ Bloating/Gas
- ☐ Bowel Changes
- ☐ Colitis/IBS
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Indigestion
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Loss of bowel control
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Reflux
- ☐ Stomach Pain
- ☐ Ulcers
- ☐ Vomiting
- ☐ Weight Trouble

GENITO-URINARY

- ☐ Bladder Trouble
- ☐ Difficulty starting flow
- ☐ Difficulty stopping flow
- ☐ Frequent Urination
- ☐ Incontinence
- ☐ Milky/Bloody Urine
- ☐ Painful Urination

MEN ONLY

- ☐ Erection Difficulties
- ☐ Lump in Testicles
- ☐ Prostate Problems

WOMEN ONLY

- ☐ Abnormal Pap Smear
- ☐ Abnormal Periods
- ☐ Breast Lumps/Pain
- ☐ Cysts/Tumors
- ☐ Discharge
- ☐ Dysmenorrhea
- ☐ Endometriosis
- ☐ Extreme Cramps
- ☐ Hot Flashes
- ☐ Miscarriage
- ☐ Spotting

Date of last period_____

Pregnant?_____

If so, how far along_____

Number of Children_____

Have you had a Mammogram?_____

OTHER:

_____

IF YOU HAVE A FAMILY HISTORY OF ANY MEDICAL PROBLEMS, PLEASE LIST THEM:

_____

_____

PLEASE LIST MEDICATIONS INCLUDING VITAMINS YOU CURRENTLY ARE TAKING:

PLEASE LIST YOUR SURGICAL HISTORY INCLUDING DATES:

ALLERGIES

SOCIAL HISTORY

DO YOU SMOKE?	IF SO, HOW MUCH?
DO YOU DRINK?	IF SO, HOW MUCH?
DO YOU EXERCISE?	IF SO, HOW OFTEN?
MARITAL STATUS:	# OF CHILDREN:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature_____ Date_____

Certificate & Assignment

I certify that I, and/or my dependent(s) have insurance coverage with_____ and assign directly to the above named clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Payment Policy

The above named clinic may use my healthcare information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I understand regardless of my insurance status, I am ultimately responsible for any changes for professional services rendered by the above named clinic.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative **Date**

_____ _____

Print Name of Patient, Parent, Guardian, or Personal Representative **Date**