Chiropractic & Wellness Center of New Haven
59 Elm Street Ste 100 • New Haven, CT 06511

Today's Date ___ / ___ / _________ Have you ever consulted a chiropractor before? Yes No

If so, who did you see?__ ____

When was your last visit? ____

Whom may we thank for referring you?____

Personal Information:

First Name:______________________________ Last Name: ______________________________ Date of Birth ___ / ___ / _________

Address: ____ City_____________________ State_______ Zip__________

Home Phone:____________________________ Work Phone__________________________ Other Phone:______________________

Email Address: ______________________________________

Your Occupation: ____ Employer: ____

Address City Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Emergency Contact Information:

First Name:______________________________ Last Name: ______________________________ Date of Birth ___ / ___ / _________

Address: ____ City_____________________ State_______ Zip__________

Phone:______________________________________

Insurance Information:

Insurance Provider:____

Insured's Full Name:____ Insured's Date of Birth: ___ / ___ / _________

Policy ID#:________________________________ Group #:____________________ Policy Holder: ☐ Self ☐ Spouse ☐ Parent

Insured's Employer: _________________________________

Address _________________________________ City _________________________________ State________ Zip______________

1. The symptoms that have prompted me to seek care today include:

2. And are the result of

☐ Accident/Injury:

☐ Work Related Auto Other: ____

☐ A worsening long term problem

☐ An Interest in:

☐ Wellness Other ____

Patient Name ____________________

3. Onset (when did you first notice your current symptoms?) ____________________

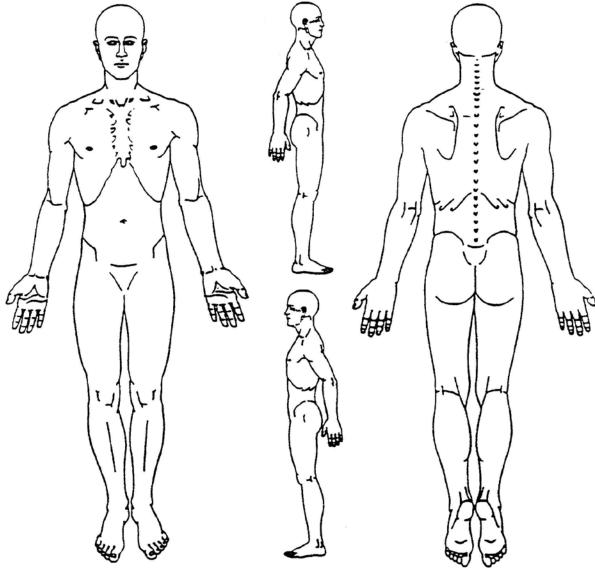
4. Intensity (How extreme are your current symptoms?) Scale of 1 - 10: ____________________

5. Duration and Timing ____________________
(How did it start and how often do you feel it?)

6. Quality of symptoms
(What does it feel like?)

- ☐ Numbness
- ☐ Tingling
- ☐ Stiffness
- ☐ Dull
- ☐ Aching
- ☐ Cramps
- ☐ Nagging
- ☐ Sharp
- ☐ Burning
- ☐ Shooting
- ☐ Throbbing
- ☐ Stabbing
- ☐ Other

7. Location
(Where does it hurt?)
Circle the area(s) on the illustration



8. Radiation
(Does it affect other areas of your body? To what areas does the pain radiate, shoot, or travel?)

____

____

9. Aggravating or Relieving Factors

(What makes it better or worse, such as time of day, movements, certain activities, etc.)

____

____

10. Prior Interventions
(What have you done to reduce the symptoms?)

- ☐ Prescription Medication ☐ Surgery ☐ Other
- ☐ Over-the-Counter drugs ☐ Accupuncture
- ☐ Homeopathic Remedies ☐ Chiropractic
- ☐ Physical Therapy ☐ Massage

11. What else should the doctor know about your current condition? ____________________

____

12. How does your current condition interfere with your:

Work or Career ____________________

Recreational Activities ____________________

Household Responsibilities ____________________

Personal Relationships ____________________

13. Review of Systems

Chiropractic care focuses on the integrity of your nervous system which controls and regulates your entire body. Please check any conditions you've HAD or currently HAVE.

a. Musculoskeletal

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
☐	☐	Osteoporosis	☐	☐	Arthritis	☐	☐	Scoliosis	☐	☐	Neck Pain
☐	☐	Knee Injuries	☐	☐	Foot/Ankle Pain	☐	☐	Shoulder Problems	☐	☐	Elbow/Wrist Pain
☐	☐	Back Problems	☐	☐	Hip Disorders	☐	☐	None			
☐	☐	TMJ Issues	☐	☐	Poor Posture						

Initials:__________

Patient Name ____________________________________

13. Review of Systems (cont.)

Chiropractic care focuses on the integrity of your nervous system which controls and regulates your entire body. Please check any conditions you've HAD or currently HAVE.

b. Neurological

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
☐	☐	Anxiety	☐	☐	Depression	☐	☐	Dizziness	☐	☐	Pins & Needles
☐	☐	Numbness	☐	☐	Headaches		☐	None			Initials ___________

c. Cardiovascular

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
☐	☐	High blood pressure	☐	☐	Low blood pressure	☐	☐	Poor circulation	☐	☐	Angina
☐	☐	Excessive bruising	☐	☐	High cholesterol		☐	None			Initials ___________

d. Respiratory

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
☐	☐		☐	☐	Apnea	☐	☐	Emphysema	☐	☐	Hey fever
☐	☐	Shortness of breath	☐	☐	Pneumonia		☐	None			Initials ___________

e. Digestive

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
☐	☐	Anorexia/Bulimia	☐	☐	Ulcer	☐	☐	Food sensitivities	☐	☐	Heartburn
☐	☐	Constipation	☐	☐	Diarrhea		☐	None			Initials ___________

f. Sensory

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
☐	☐	Blurred vision	☐	☐	Hearing loss	☐	☐	Loss of smell	☐	☐	Loss of taste
☐	☐	Ringing ears	☐	☐	Chronic ear infection		☐	None			Initials ___________

g. Integumentary

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
☐	☐	Skin cancer	☐	☐	Psoriasis	☐	☐	Eczema	☐	☐	Acne
☐	☐	Hair loss	☐	☐	Rash		☐	None			Initials ___________

h. Endocrine

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
☐	☐	Thyroid issues	☐	☐	Immune disorders	☐	☐	Hypoglycemia	☐	☐	Frequent infection
☐	☐	Swollen glands	☐	☐	Low energy		☐	None			Initials ___________

i. Genitourinary

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
☐	☐	Anxiety	☐	☐	Infertility	☐	☐	Bedwetting	☐	☐	Prostate issues
☐	☐	Erectile dysfunction	☐	☐	PMS symptoms		☐	None			Initials ___________

i. Constitutional

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
☐	☐	Fainting	☐	☐	Low libido	☐	☐	Poor appetite	☐	☐	Fatigue
☐	☐	Weakness	☐	☐	Sudden weight change		☐	None			Initials ___________

Patient Name ______________________________

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

14. Illnesses Check the illnesses you have HAD i the past or HAVE now.

HAD	HAVE	
☐	☐	AIDS
☐	☐	Alcoholism
☐	☐	Allergies
☐	☐	Arteriosclerosis
☐	☐	Arthritis
☐	☐	Cancer
☐	☐	Chickenpox
☐	☐	Diabetes
☐	☐	Eczema
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Glaucoma
☐	☐	Goiter
☐	☐	Gout
☐	☐	Heart disease
☐	☐	Hepatitis
☐	☐	Malaria
☐	☐	Measles
☐	☐	Multiple sclerosis
☐	☐	Mumps
☐	☐	Pneumonia
☐	☐	Polio
☐	☐	Rheumatic fever
☐	☐	Scarlet fever
☐	☐	STD
☐	☐	Stroke
☐	☐	Tuberculosis
☐	☐	Typhoid fever
☐	☐	Ulcer
☐	☐	Other

15. Operations: Surgical interventions, which may or may not have included hospitalization.

HAD	HAVE	
☐	☐	Appendix removal
☐	☐	Bypass surgery
☐	☐	Cancer
☐	☐	Surgery
☐	☐	Elective surgery
☐	☐	Eye surgery
☐	☐	Hysterectomy
☐	☐	Pacemaker
☐	☐	Tonsillectomy
☐	☐	Vasectomy
☐	☐	Other

17. Injuries Have you ever:

- ☐ Had a fractured or broken bone
- ☐ Had a spine or nerve disorder
- ☐ Been injured by an accident
- ☐ Been knocked unconscious
- ☐ Used a crutch or other support
- ☐ Used neck or back bracing
- ☐ Had a body peircing

16. Treatments Check the ones you have received in the PAST or are CURRENTLY receiving

PAST	PRESENT	
☐	☐	Acupuncture
☐	☐	Antibiotics
☐	☐	Birth control pills
☐	☐	Blood transfusions
☐	☐	Chemotherapy
☐	☐	Chiropractic care
☐	☐	Dialysis
☐	☐	Dizziness
☐	☐	Herbs
☐	☐	Homeopathy
☐	☐	Hormone replacements
☐	☐	Massage therapy
☐	☐	Physical therapy
☐	☐	Nutritional supplements
☐	☐	Medications

18. Family History

Some health issues are hereditary. Tell us about the health of your immediate family members.

RELATIVE	AGE	STATE OF HEALTH	ILLNESSES	AGE AT DEATH	CAUSE OF DEATH
Mother	_____	☐ Good ☐ Poor	______________	____	☐ Natural ☐ Illness
Father	_____	☐ Good ☐ Poor	______________	____	☐ Natural ☐ Illness
Sister	_____	☐ Good ☐ Poor	______________	____	☐ Natural ☐ Illness
Sister	_____	☐ Good ☐ Poor	______________	____	☐ Natural ☐ Illness
Brother	_____	☐ Good ☐ Poor	______________	____	☐ Natural ☐ Illness
Brother	_____	☐ Good ☐ Poor	______________	____	☐ Natural ☐ Illness

19. Are there any other hereditary health issues that we should know about? ______________________________

____

____

____

Patient Name ________________________

20. Social History

Tell us about your health habits and stress levels.

Alcohol Use	☐ Daily	☐ Weekly	How Much? ____________
Coffee Use	☐ Daily	☐ Weekly	How Much? ____________
Tobacco Use	☐ Daily	☐ Weekly	How Much? ____________
Exercising	☐ Daily	☐ Weekly	How Much? ____________
Pain Relievers	☐ Daily	☐ Weekly	How Much? ____________
Soft Drinks	☐ Daily	☐ Weekly	How Much? ____________
Water Intake	☐ Daily	☐ Weekly	How Much? ____________

Hobbies

Prayer or Meditation?	☐ Yes	☐ No
Job Pressure/Stress	☐ Yes	☐ No
Financial Pressure?	☐ Yes	☐ No
Vaccinated?	☐ Yes	☐ No
Mercury Fillings?	☐ Yes	☐ No
Recreational Drugs?	☐ Yes	☐ No

21. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	None	Mildly	Moderately	Severly
Sitting	☐	☐	☐	☐
Rising out of Chair	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Lying Down	☐	☐	☐	☐
Bending Over	☐	☐	☐	☐
Climbing Stairs	☐	☐	☐	☐
Using a computer	☐	☐	☐	☐
Getting in/out of Car	☐	☐	☐	☐
Driving a car	☐	☐	☐	☐
Looking over shoulder	☐	☐	☐	☐
Caring for family	☐	☐	☐	☐

	None	Mildly	Moderately	Severly
Grocery Shopping	☐	☐	☐	☐
Household Chores	☐	☐	☐	☐
Lifting objects	☐	☐	☐	☐
Reaching overhead	☐	☐	☐	☐
Showering/Bathing	☐	☐	☐	☐
Getting dressed	☐	☐	☐	☐
Love life	☐	☐	☐	☐
Getting to sleep	☐	☐	☐	☐
Concetrating	☐	☐	☐	☐
Exercising	☐	☐	☐	☐
Yard Work	☐	☐	☐	☐
Staying asleep	☐	☐	☐	☐

22. What is the major stressor in your life? ________________________

____

23. How much sleep do you average per night? ________________________

24. What is the approximate age of your mattress & pillow? ________________________

25. What is your preferred sleeping position? ________________________

26. Describe your typical eating habits ☐ **Skip Breakfast** ☐ **Two Meals/day** ☐ **Three meals/day** ☐ **Snacking between meals**

27. What would be the most significant thing that you could do to improve your health? ________________________

____

28. In addition to the main reason for your visit today, what additional health goals do you have? ________________________

____

____

Patient Name ____________________________________

Acknowledgements

Initials

__________ I instruct the chiropractor to deliver the care that, in her or her pr0fessional judgement, ca n best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

__________ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

__________ I grant permissions to be called to confirm or reschedule an appointment.

__________ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

__________ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor child, print child's full name:____

Signature ____ Date______________________

Print Name ____