NEW PATIENT INFORMATION

Watson Chiropractic & Wellness Center

PATIENT INFORMATION

Last Name:____________________________ First Name:____________________________ Date:______________________________

Address:______________________________City:_________________________________ State:___________ Zip_______________

Birthdate: ___ ___/___ ___ /___ ___ ___ ___ ☐ Male ☐ Female Age_____________ Social Security #:____________________

Occupation: ___________________________ Employer/School:______________________ Primary Care Doctor: ________________

Race (check one): ☐ American Indian or Alaskan native ☐ Asian ☐ African American ☐ Hispanic or Latino

☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Decline to answer

Status: ☐ Married ☐Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered

Spouse's Name: ________________________Spouse's Employer: ____

Whom may we thank for referring you? ____

CONTACT INFORMATION

Home Phone: __________________________ Cell Phone: ____________________________Work Phone: ________________________

Best time and place to reach you: ____ Email: ____________________________

In case of emergency, please contact:

Name: _____________________________________ Relationship: ____________________ Phone:_____________________________

INSURANCE

Primary Subscriber: ____Birthdate: ___ ___/___ ___ /___ ___ ___ ___

Relationship to patient: __________________ Insurance Company: ___________________ ___________________________________

Social Security #: _______________________ ID #: __________________________________Group #: ___________________________

Additional Insurance:

Primary Subscriber:____Birthdate: ___ ___/___ ___ /___ ___ ___ ___

Relationship to patient:__________________ Insurance Company:____________________ ___________________________________

Social Security #: _______________________ ID #: __________________________________Group #: ___________________________

HEALTH HISTORY

Major surgeries (include dates):____

Major accidents or falls (include dates): ____

Broken bones? ____ Do you wear a shoe lift or stabilizing orthotic? ☐ Yes ☐ No

Is your current condition due to an accident? ☐ Yes ☐ No Date of accident: ____

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other ____

Diseases you have had:

- ☐ Anemia
- ☐ Arthritis
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Eczema
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ HIV positive
- ☐ Influenza
- ☐ Lumbago
- ☐ Measles
- ☐ Mental Disorders
- ☐ Mumps
- ☐ Pleurisy
- ☐ Polio
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Small Pox
- ☐ Tuberculosis
- ☐ Thyroid
- ☐ Whooping Cough

Check any conditions you've experienced in the past 6 months:

General

- ☐ Allergies
- ☐ Fatigue
- ☐ Fever
- ☐ Loss of Sleep
- ☐ Headaches

Nervous System

- ☐ Anxiety
- ☐ Cold/tingling extremities
- ☐ Confusion
- ☐ Convulsions
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Forgetfulness
- ☐ Numbness
- ☐ Paralysis
- ☐ Stress

Musculo/Skeletal

- ☐ Arm pain
- ☐ Difficulty chewing/clicking jaw
- ☐ General stiffness
- ☐ Joint pain/stiffness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Pain between shoulders
- ☐ Walking problems

Gastro/Intestinal

- ☐ Abdominal cramps
- ☐ Black/bloody stool
- ☐ Colitis
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Frequent nausea
- ☐ Gall bladder problems
- ☐ Gas/bloating after meals
- ☐ Heart trouble
- ☐ Hemorrhoids
- ☐ Liver problems
- ☐ Poor/excessive appetite
- ☐ Vomiting
- ☐ Weight trouble

Cardio/Vascular/Respiratory

- ☐ Ankle swelling
- ☐ Blood pressure problems
- ☐ Chest pain
- ☐ Heart problems
- ☐ Irregular heartbeat
- ☐ Lung problems/congestion
- ☐ Shortness of breath
- ☐ Stroke
- ☐ Varicose veins

Ear/Eye/Nose/Throat

- ☐ Dental problems
- ☐ Ear aches
- ☐ Hearing difficulty
- ☐ Sore throat
- ☐ Stuffed nose
- ☐ Vision problems

Urinary

- ☐ Bladder trouble
- ☐ Painful/excessive urination
- ☐ Discolored urine

Male

- ☐ Prostate/sexual dysfunction

Female

- ☐ Breast pain/lumps
- ☐ Menstrual irregularity
- ☐ Menstrual cramps
- ☐ Vaginal pain/infection
- ☐ Other

When was your last period?

____

Are you pregnant?

☐ Yes ☐ No ☐ Not sure

LIFESTYLE

Smoking

- ☐ Never
- ☐ Formerly
- ☐ Occasionally
- ☐ Daily

Personal Habits

- ☐ Alcohol
- ☐ Coffee/caffeine drinks
- ☐ High stress level

Exercise

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

Work Activity

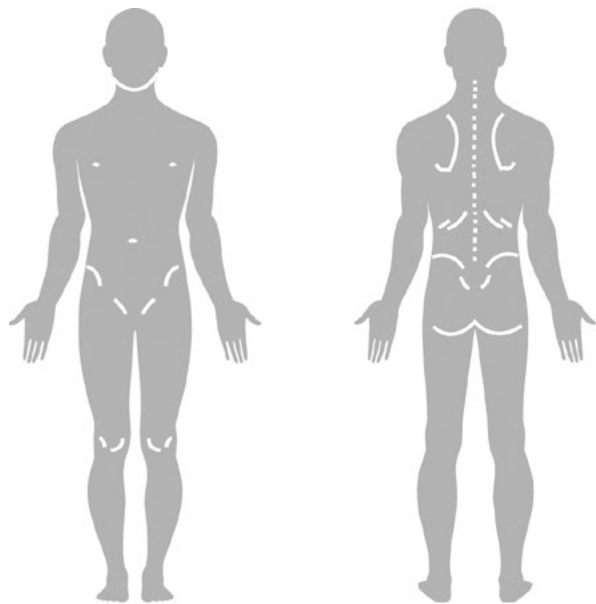
- ☐ Sitting
- ☐ Standing
- ☐ Light labor
- ☐ Heavy labor

REASON FOR VISIT

Reason for today's visit: ____

When did your symptoms appear? __________________ Is this condition getting progressively worse? ☐ Yes ☐ No

Mark an X where you have pain, numbness or tingling:



Type of pain:

☐ Aching ☐ Numbness ☐ Stiffness
☐ Burning ☐ Sharp ☐ Swelling
☐ Cramps ☐ Shooting ☐ Throbbing
☐ Dull ☐ Stabbing ☐ Tingling
☐ Other ______________________________
____

Rate the severity of your pain:

1 2 3 4 5 6 7 8 9 10

Least severe Most severe

Is your pain constant or does it come and go?

____

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down

Condition interferes with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Other __________________

What treatment have you already received for your condition? ☐ Medications ☐ Physical therapy ☐ Chiropractic services
☐ Surgery ☐ Stretching ☐ Ice ☐ Heat ☐ None ☐ Other ______________________________

Names of other doctors who have treated you for this condition? ______________________________

CURRENT MEDICATIONS

What medications are you currently taking? Please include dosages. ______________________________

____

What herbs, vitamins, and supplements are you currently taking? ______________________________

____

Any allergies to medications? Please include reactions (example: vomiting, rash, hives, etc.) __________________

____