Mountain View Chiropractic, Dr. Lisa Beighle New Patient Forms

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____-_____-_____ Work Phone:_____-_____-_____ Cell Phone:_____-_____-_____

Email Address_____@_____Occupation:_____

Date of Birth:_____/_____/_____Social Security #:_____-_____-_____Gender: Male Female

Marital Status: M S W D P Primary Care Physician/Address:_____

PCP Phone#_____-____-_____ PCP Fax #____-___-____Would you like us to send a report? ☐ Y ☐ N

List any Allergies:

☐ Animals ☐ Bees ☐ Dairy ☐ Dust ☐ Eggs ☐ Latex ☐ Medications(list)_____

☐ Pollen ☐ Rubber ☐ Seasonal ☐ Shellfish ☐ Soaps ☐ Wheat ☐ X-Ray Dye ☐ Other_____

List any Surgeries:

☐ Back ☐ Brain ☐ Elbow ☐ Foot ☐ Hip ☐ Knee ☐ Neck ☐ Neurological ☐ Shoulder ☐ Wrist

☐ Other:_____

List ALL past Medical History/Conditions:

☐ Ankle Pain ☐ Arm Pain ☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Broken Bones ☐ Cancer ☐ Chest Pain

☐ Depression ☐ Diabetes ☐ Dizziness ☐ Elbow Pain ☐ Epilepsy ☐ Eye/Vision Problems ☐ Fainting

☐ Fatigue ☐ Foot Pain ☐ Genetic Spinal Condition ☐ Hand Pain ☐ Headaches ☐ Hearing Problems

☐ Hepatitis ☐ High Blood Pressure ☐ Hip Pain ☐ HIV/AIDS ☐ Jaw Pain ☐ Joint Stiffness ☐ Knee Pain

☐ Leg Pain ☐ Menstrual Problems ☐ Mid-Back Pain ☐ Minor Heart Problems ☐ Multiple Sclerosis

☐ Neck Pain ☐ Neurological Problems ☐ Pacemaker ☐ Parkinson's ☐ Polio ☐ Prostate Problems

☐ Shoulder Pain ☐ Significant Weight Change ☐ Spinal Cord Injury ☐ Sprain/Strain ☐ Stroke/Heart Attack

☐ Other:_____

List your Family History:

☐Arthritis ☐Asthma ☐Back Pain ☐Cancer ☐Depression ☐Diabetes ☐Epilepsy

☐Genetic Spinal Condition ☐High Blood Pressure ☐Heart Problems ☐Multiple Sclerosis

☐Neurological Problems ☐Parkinson's ☐Polio ☐Prostate Problems ☐Stroke/Heart Attack

☐Other:_____

List Medications you are taking:

1._____ 2._____

3._____ 4._____

5._____ 6._____

Do you take vitamins and supplements? ☐Yes ☐No (If yes please list below)

1._____ 2._____

3._____ 4._____

5._____ 6._____

Would you like basic vitamin and supplement recommendations? ☐Yes ☐No

Have you had any auto or other accidents? ☐Yes ☐No (If yes please describe):_____

_____

Date of last physical examination:_____ Do you Smoke? ☐Yes ☐No

Do you drink alcohol? ☐No ☐Yes-frequency?_____

Do you drink caffeine? ☐No ☐Yes-frequency?_____

Do you exercise? ☐No ☐Yes –What forms and how often?_____

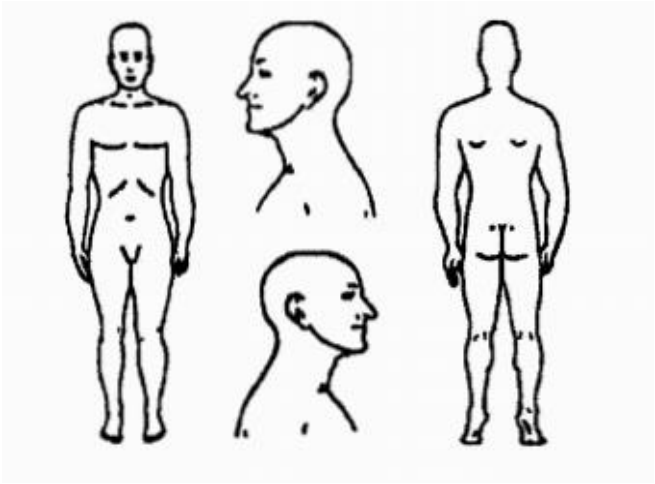
Have you ever had chiropractic care? ☐No ☐Yes (complete information below):

When?_____Why?_____
Where?_____

When was your last adjustment?_____

Were X-Rays taken?_____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW:



Main Reason for consulting the office:

- ☐ **Become Pain Free**
- ☐ **Explanation of my condition**
- ☐ **Learn how to care for my condition**
- ☐ **Reduce symptoms**
- ☐ **Resume normal activity level**

What is your major complaint?_____Date problem began?_____

How did this problem begin (falling, lifting, accident, etc.?_____

How is your condition changing? ☐ **Getting better** ☐ **Getting worse** ☐ **Not changing**

Have you had this condition in the past? ☐ **Yes** ☐ **No Location of pain:** ☐ **Left** ☐ **Right** ☐ **Center** ☐ **Both**

Please rate your pain on a scale of 1 to 10 (0=no pain and 10=excruciating pain)

☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10**

Intensity: ☐ **Minimum** ☐ **Mild** ☐ **Moderate** ☐ **Severe** ☐ **Unbearable**

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0=no effect and 10=no possible activities) ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10**

Describe the nature of your symptoms: ☐ **Burning** ☐ **Dull** ☐ **Numb** ☐ **(Radiating Pain_____)**

☐ **Sharp** ☐ **Shooting** ☐ **Stabbing** ☐ **Throbbing** ☐ **Tightness** ☐ **Tingling** ☐ **Other:_____**

What activities aggravate your condition (working, exercise, etc.)?_____

What makes your pain better (ice, heat, massage, etc.)?_____

How often do you experience your symptoms? :

☐ **Constantly (76-100% of the day)** ☐ **frequently (51-75% of the day)**

☐ **Occasionally (26-50% of the day)** ☐ **intermittently (0-25% of the day)**

What is your second complaint?_____Date problem began?_____

How did this problem begin (falling, lifting, accident, etc.?_____

How is your condition changing? ☐Getting better ☐Getting worse ☐Not changing

Have you had this condition in the past? ☐Yes ☐No Location of pain: ☐Left ☐Right ☐Center ☐Both

Please rate your pain on a scale of 1 to 10 (0=no pain and 10=excruciating pain)

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Intensity: ☐Minimum ☐Mild ☐Moderate ☐Severe ☐Unbearable

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0=no effect and 10=no possible activities) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9☐10

Describe the nature of your symptoms: ☐Burning ☐Dull ☐Numb ☐(Radiating Pain_____)

☐Sharp ☐Shooting ☐Stabbing ☐Throbbing ☐Tightness ☐Tingling ☐Other:_____

What activities aggravate your condition (working, exercise, etc.)?_____

What makes your pain better (ice, heat, massage, etc.)?_____

How often do you experience your symptoms? :

☐ Constantly (76-100% of the day) ☐ frequently (51-75% of the day)

☐ Occasionally (26-50% of the day) ☐ intermittently (0-25% of the day)