NEW PATIENT INFORMATION

Check Any of the Following That May Apply To You

Health Issues:

☐ Over Weight	☐ Arthritis	☐ Heart	☐ Sleep Disorder(s)
☐ High Stress	☐ AIDS or HIV	☐ Allergies	☐ Chronic Fatigue
☐ Diabetes	☐ Frequent Illnesses	☐ Epilepsy	☐ Endocrine Disorders
☐ Under Weight	☐ Poor Diet	☐ Nervousness	☐ Genetic Disorder(s)
☐ Cancer	☐ Lungs	☐ Bone Conditions	
☐ History of Polio	☐ Infections	☐ Sleeplessness	☐ Other:_____
☐ None of these	☐ None of these	☐ None of these	☐ None of these

Intake Or Use: **If Female - is there <u>any</u> possibility that you are pregnant?** ☐Yes ☐ No

☐ Alcohol	☐ Tobacco	☐ Pain Relievers	☐ None of these
☐ Sleeping Pills	☐ Birth Control	☐ Caffeine	☐ Other:_____

Muscles-Skeleton
- ☐ Pain in: Low Back
- ☐ Mid-Back
- ☐ Neck
- ☐ Hips / Legs
- ☐ Shoulders / Arms
- ☐ None of these

Circulation-Breathing
- ☐ Chest Pain / Coughing
- ☐ Lungs / Breathing / Wheezing
- ☐ Blood Pressure
- ☐ Heart Rate
- ☐ Poor Circulation
- ☐ None of these

Eye-Ear-Nose-Throat
- ☐ Eyes / Vision
- ☐ Dental / TMJ
- ☐ Throat / Voice
- ☐ Ears / Hearing
- ☐ Sinus Pain / Drainage
- ☐ None of these

Problems within the Last Six Months

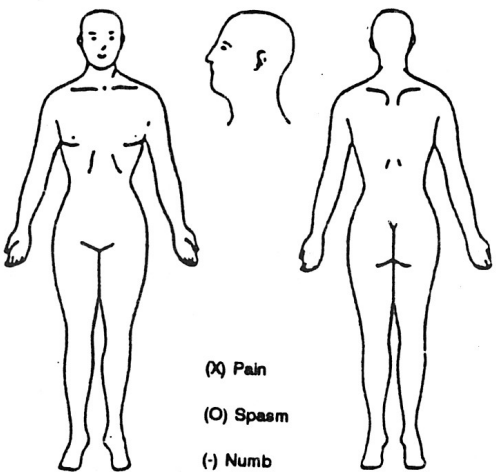
Nerve System
- ☐ Headaches
- ☐ Nervousness
- ☐ Numbness
- ☐ Weak Muscles
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Depression
- ☐ Fainting / Seizures
- ☐ Shaking / Tremors
- ☐ Cold Hands / Feet
- ☐ Stress Reactions
- ☐ None of these

Digestion-Elimination
- ☐ Poor Appetite
- ☐ Excessive Thirst
- ☐ Nausea
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Weight Loss / Gain
- ☐ Heartburn
- ☐ Change In Stools
- ☐ None of these

Urinary-Genitals
- ☐ Pain With Urination
- ☐ Infrequent Urination
- ☐ Frequent Urination
- ☐ Weak Stream
- ☐ Bladder Control
- ☐ Genital concerns
- ☐ None of these

Female Only:
- ☐ Menstrual Problems
- ☐ Back Pain with Period
- ☐ None of these
- ☐ Breast Implants
- ☐ Breast Lumps/Pain
- ☐ None of these

Areas Of Concern:



OFFICE ONLY:
BP:_____/____
Pulse:_____
Resp:_____
Temp:_____
Sleep/pm:____
Ht:_____
Wt:_____
BMI:_____
Shoe Obs:____

I understand that care in this office involves making judgements that are based upon the facts known by the doctor. The above information is true and complete to the best of my knowledge, I understand the risks of care, and I give consent to the doctor to administer Chiropractic / Physio-therapeutic care / modalities and to use any testimonials I may subsequently share with him as to my care.

_____

Patient's Signature *Date*

GENESIS CHIROPRACTIC

Welcome to our office! Please take whatever time needed to share the following details about you, your life, and your health. If you do not understand any of these questions, please feel free to ask about them.

Your Personal Information

Name:_____Today's Date:_____/_____/_____

Age:_____ ☐ Male ☐ Female Date Of Birth:_____/_____/_____ Last 4 ONLY of SS # - ___ ___ ___ ___

Address:_____City:_____

State:_____ Zip:_____ Your E-mail: _____@_____

Cell Ph:_(_____)-_____ Receives Texts? Yes ☐ No ☐ Home Ph: (_____)-_____

Employer:_____ Work you Perform: _____

Spouse / Partner:_____DOB?____/____/___ Best Phone:(____)-_____-_____

Children & Ages:_____

Who To Thank For Telling You About Us?_____

Your Current Concern(s)

Primary Reason for Today's Visit: _____ NA ☐ (Wellbeing)

Check the Severity of Your Complaint: (Mild) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ (Severe) NA ☐ (Wellbeing)

My Health Problems have been: ☐ Rapidly getting worse ☐ Staying about the same NA ☐ (Wellbeing)

My Pain is: ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional ☐ Very Severe ☐ Severe NA ☐ (Wellbeing)

☐ Moderate ☐ Mild ☐ Dull ☐ Sharp ☐ Shooting ☐ Aching ☐ Burning ☐ Numbing ☐ Tingling ☐ Throbbing

☐ Other_____ When Did This Begin?_____ Experienced Previously? ☐ Yes ☐ Never

Is This Condition: ☐ Job Related ☐ Auto Accident ☐ Fall or Injury ☐ Other:_____

Other Dr Seen For This:_____Diagnosis: _____

How Long did you see the Dr? _____ Results? _____

Other Dr Seen For This: _____Diagnosis: _____

How Long did you see the Dr? _____ Results? _____

Other or Secondary Health Concerns:_____

Now on: ☐ Pain Killers / Relaxants ☐ Blood Pressure Rx ☐ Antibiotics ☐ Other_____

Your Health History

Surgeries: ☐ Eyes / Ears / Nose / Throat ☐ Head/Neck ☐ Back /Spine ☐ Chest / Heart / Lungs ☐ Abdominal

☐ Other:_____

Previous Hospitalizations? ☐ Yes:_____ ☐ No

Accidents, Fractures or Falls? ☐ Yes:_____ ☐ No

Previous Chiropractic Care? ☐ Yes:_____ ☐ No

Similar Problem In Family? ☐ Yes:_____ ☐ No

Co-Workers: Similar Problems? ☐ Yes:_____ ☐ No

Do You Workout or Exercise? ☐ Yes:_____ ☐ No

NP GENESIS PG1 V3

PLEASE COMPLETE OTHER SIDE