NEW PATIENT INFORMATION .

Please complete all questions. Thank you.

(Please Print)

Name:	Today's Date:	
Address:	City/State/Zip	
Home Phone:	Work Phone:	Cell/Pager:
Birth date: Age:	Email:	
Social Security #:	Marital Status: M W D S	
Spouse's Name:	Children/Age:	
Employer:	Address:	Job Description:

Who may we thank for referring you? Body shop Newspaper Diminished Value Company Magazine Current Patient
_____ Internet Attorney _____ Family/Friend _____ Wrecker service

Sign _____ Date _____

Current health complaints/reasons for consulting our office:

1. _____
2. _____
3. _____

Surgeries _____ List fractures and dates_____
List all medications you are now taking._____
List any supplement you are currently taking._____
Have you been treated for ANY health conditions in the last year? _____
Describe: _____
What x-rays have you had in the last five years? _____
Women: Is there any possibility you are pregnant? _____
Do you suffer from any condition(s) other than that which you are now consulting us? _____
_____
Have you had previous chiropractic care? _____ If so, Dr's name &last visit_____
Do you have health insurance? _____ Name of Company_____
Your Auto insurance: _____Policy: _____Agent's Name: _____
Have you retained an attorney: ( ) Yes ( ) No Name: _____

Date of your accident: _____ Were you taken to emergency room? Yes No

1. **Description of Accident/Injury/Onset** *

Enter a full description of the accident, injury or onset in the space below

What was the patient doing at the time?
Driver Passenger Pedestrian On a bicycle On a Motorcycle

What direction did the impact come from?
The Front The Left The Right The Rear

What speed were you traveling? _____What speed was the other driver traveling?_____

Where were you looking at the time?
Looking straight ahead Looking down Looking to the right
Looking to the left Looking over your shoulder

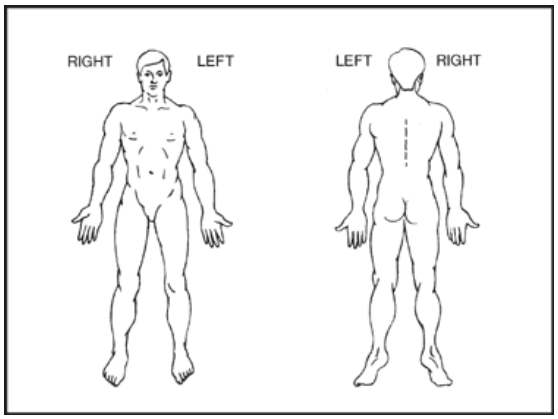
Did you have your seat belt on? YES NO **Did your head hit the head rest?** YES NO

What happened after the impact?
Felt disoriented Felt discomfort Felt immediate pain Felt tightness
Lost consciousness Was frightened Was stunned Went to the hospital

Did the doctors take x-rays? YES NO
What regions needed to be x-rayed?
Cervical Thoracic Lumbar Pelvic
R/L Shoulder R/L Arm R/L Leg R/L Knee R/L Ankle R/L Foot

What medications were prescribed?_____ Was a police report filed? YES NO

Where is the pain location?



How would you rate the level of discomfort right now on a scale of 10?
1 2 3 4 5 6 7 8 9 10

FIRST COMPLAINT

What is the frequency of the discomfort you are feeling?
10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How bad is the discomfort at its worst?
1 2 3 4 5 6 7 8 9 10

How would you rate the discomfort at its best?
1 2 3 4 5 6 7 8 9 10

Describe the onset of the discomfort? Gradual Sudden

When did the discomfort begin?_____
_____

Since the problem began have the symptoms been getting: better worse same

What aggravates the discomfort? Bending bowling carrying cleaning climbing cooking coughing crawling cycling dressing driving eating exercising gardening jumping kneeling lifting lying medications playing golf playing tennis pulling pushing reaching resting running sex sitting sleeping sliding sneezing standing stooping swinging turning twisting typing walking working

What percentage worse is the discomfort after it is aggravated?
10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How many minutes will the discomfort remain that way?_____

What relieves the discomfort? Bending bowling carrying cleaning climbing cooking coughing crawling cycling dressing driving eating exercising gardening jumping kneeling lifting lying medications playing golf playing tennis pulling pushing reaching resting running sex sitting sleeping sliding sneezing standing stooping swinging turning twisting typing walking working

What percentage would you say that the discomfort improves?
10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

What is the quality of the discomfort? Aching anguish burning continuous deep depression despair discomfort dull frequent insidious intense intermittent malaise melancholy mild moderate numb numbness occasional pain random severe self loathing sharp shooting superficial throbbing tingling tightness

When is the discomfort at its worst? Morning Afternoon Evening Just before bed

SECOND COMPLAINT

What is the frequency of the discomfort you are feeling?
10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How bad is the discomfort at its worst?
1 2 3 4 5 6 7 8 9 10

How would you rate the discomfort at its best?
1 2 3 4 5 6 7 8 9 10

Describe the onset of the discomfort? Gradual Sudden

When did the discomfort begin?_____
_____

Since the problem began have the symptoms been getting: better worse same

What aggravates the discomfort? Bending bowling carrying cleaning climbing cooking coughing crawling cycling dressing driving eating exercising gardening jumping kneeling lifting lying medications playing golf playing tennis pulling pushing reaching resting running sex sitting sleeping sliding sneezing standing stooping swinging turning twisting typing walking working

What percentage worse is the discomfort after it is aggravated?
10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How many minutes will the discomfort remain that way?_____

What relieves the discomfort? Bending bowling carrying cleaning climbing cooking coughing crawling cycling dressing driving eating exercising gardening jumping kneeling lifting lying medications playing golf playing tennis pulling pushing reaching resting running sex sitting sleeping sliding sneezing standing stooping swinging turning twisting typing walking working

What percentage would you say that the discomfort improves?
10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

What is the quality of the discomfort? Aching anguish burning continuous deep depression despair discomfort dull frequent insidious intense intermittent malaise melancholy mild moderate numb numbness occasional pain random severe self loathing sharp shooting superficial throbbing tingling tightness

When is the discomfort at its worst? Morning Afternoon Evening Just before bed

THIRD COMPLAINT

What is the frequency of the discomfort you are feeling?
10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How bad is the discomfort at its worst?
1 2 3 4 5 6 7 8 9 10

How would you rate the discomfort at its best?
1 2 3 4 5 6 7 8 9 10

Describe the onset of the discomfort? Gradual Sudden

When did the discomfort begin?_____
_____

Since the problem began have the symptoms been getting: better worse same

What aggravates the discomfort? Bending bowling carrying cleaning climbing cooking coughing crawling cycling dressing driving eating exercising gardening jumping kneeling lifting lying medications playing golf playing tennis pulling pushing reaching resting running sex sitting sleeping sliding sneezing standing stooping swinging turning twisting typing walking working

What percentage worse is the discomfort after it is aggravated?
10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How many minutes will the discomfort remain that way?_____

What relieves the discomfort? Bending bowling carrying cleaning climbing cooking coughing crawling cycling dressing driving eating exercising gardening jumping kneeling lifting lying medications playing golf playing tennis pulling pushing reaching resting running sex sitting sleeping sliding sneezing standing stooping swinging turning twisting typing walking working

What percentage would you say that the discomfort improves?
10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

What is the quality of the discomfort? Aching anguish burning continuous deep depression despair discomfort dull frequent insidious intense intermittent malaise melancholy mild moderate numb numbness occasional pain random severe self loathing sharp shooting superficial throbbing tingling tightness

When is the discomfort at its worst? Morning Afternoon Evening Just before bed

ADL Affected Home Activities –

What home activities would the patient like to be able to do?
clean the bathroom do the laundry make the beds mop the floors mow the lawn stand at the stove wash the dishes wash the windows work in the garden vacuum the house

How long is the patient able to perform these activities before feeling uncomfortable?_____

How many hours does the patient feel they need to do this task?_____

Stand-

What is the patient's goal for sitting?
At the office 30 min 1hr 4hr 8hr

How long is the patient currently able to stand before feeling uncomfortable?_____

How many hours does the patient feel they need to stand?_____

Walking-

How s the patient's walking affected?
1 mile at work in the park at the beach the golf course the dog upstairs without pain

How many hours is the patient currently able to walk?_____

What distance can the patient walk in miles?_____

How many hours does the patient feel they need to walk?_____

What is the ideal distance the patient feels they should be able to walk in miles?_____

Personal Care-

Which personal care activities is the patient unable to do without discomfort?
Bathe Brush hair Brush teeth Shower Shave

How long is the patient able to perform these activities before feeling uncomfortable?_____

How many hours does the patient feel they need to do this task?_____

Sitting-

What is the patient's goal for sitting? At the office 30 min 1hr 4hr 8hr
In a reclining position in a car upright while driving

How long is the patient currently able to sit before feeling uncomfortable?_____

How many hours does the patient feel they need to sit?_____

Running-

How is the patient's running affected? A marathon Competitively for recreation in the park With a group with friends with children
How many hours is the patient currently able to run?_____
What is the distance in miles that the patient can currently run?_____
How many hours does the patient feel they need to run?_____
How many miles does the patient feel that they should be able to run?_____

Lifting-

What is the patient's goal for lifting? Small objects less than 30lbs 30lbs 50lbs 80lbs Weights at gym over head from floor twist carry

How many pounds can the patient lift before noticing the discomfort?_____

How many pounds does the patient feel they need to lift?_____

Driving-

How long is the patient currently able to drive before feeling uncomfortable?_____

How many hours does the patient feel they need to drive?_____

Athletic Activities-

What is the patient's athletic goal?_____
_____

How much time can the patient play for before feeling uncomfortable?_____

How many hours does the patient feel they need to play?_____

Work-

How long is the patient currently able to work before feeling uncomfortable?_____

How many hours does the patient feel they need to work?_____

Lack of Enjoyment-

What is the patient expressing a lack of enjoyment in? nothing aspirin bathing bending boating carrying changing positions chiropractic care cleaning climbing cooking coughing crashing dressing driving eating exercising gardening going to the bathroom golfing having sex heat ibuprofen ice jumping kneeling lifting lying down most movements playing baseball playing basketball playing football playing racket ball playing soccer playing tennis pulling reaching resting running shaving sitting sleeping skiing sliding sneezing snowboarding squatting stooping stress turning twisting typing walking working

Duties Under Duress—

Which duties is the patient doing under duress? Bending bowling carrying cleaning climbing cooking coughing crawling cycling dressing driving eating exercising gardening jumping kneeling lifting lying medications playing golf playing tennis pulling pushing reaching resting running sex sitting sleeping sliding sneezing standing stooping swinging turning twisting typing walking working

Have you been treated by another doctor since the accident? ( ) Yes ( ) No If yes, please list name and address:
_____

What type of treatment did you receive? _____

What type of care are you looking for? Temporary relief_____ Maximum Correction_____

I hereby authorize Dr. Aaron J. Richardet , Dr. Jason A. Graf, Dr. Nikki Bailey (and whomever they may designate as his assistant(s) to administer chiropractic care as he deems necessary to my _____ (indicate relationship of child) named_____.

The above information is true and accurate to the best of my knowledge.
Patient's or Guardian's Signature: _____Date:_____

Witness: _____Date:_____