Health WEBB LLC
FAMILY CHIROPRACTIC AND WELLNESS

New Patient Information

Patient's Full Name: _____ **Age:**_____ **Sex:** _____ **Date:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

E-Mail Address:_____ **Date of Birth:** ____/____/_____ **◊ Male ◊ Female**

Patient Social Security #: _____-____-_____

Occupation: _____ **Employer:** _____

Status: ◊ Employed ◊ Full Time Student ◊ Part Time Student ◊ Retired ◊ Unemployed

Who may we thank for referring you? ◊ Friend ◊ Relative ◊ Physician ◊ Website ◊ Soccer ◊Other_____

◊ Married (Spouse's Name: _____) ◊ Single ◊ Widowed ◊ Divorced ◊ Separated

Ethnicity (check only 1) ◊ American Indian ◊ Asian ◊ Alaska Native ◊ White ◊ Black or African American ◊ Native Hawaiian ◊ Other Pacific Islander ◊ Decline to State Ethnicity (check only 1) ◊ Decline to State ◊ Hispanic or Latino ◊ Not Hispanic or Latino

Smoking Status (check only 1) ◊ Current Every day Smoker ◊ Current Some Day Smoker ◊ Former Smoker ◊ Never Smoker Smoking Start Date: _____ End Date: _____

In effort to quit smoking, I am currently taking: _____

Preferred Language: _____ **HEIGHT:** ____ft ____ in **WEIGHT:** _____ pounds

What medications are you currently taking?

_____
_____

Do you have any allergies to medication? ◊ Yes ◊ No

Allergy:	Reaction:

Are you currently taking any anti-coagulant or blood thinning medication? ◊ Yes ◊ No

Please describe any family history of:

Cancer:	Stroke:
Diabetes I or II:	Heart Disease:
Headaches:	Back pain:
Migraines:	Scoliosis:
Allergies:	Arthritis:

Family Physician/Internist: _____ City/State:_____ Phone: _____

May we share your information in our patient records with your above listed physician for integrated care? ◊ YES ◊ NO

Have you had previous Chiropractic Care: ◊ Yes ◊ No

If yes, for what problem? _____

Doctor's Name: _____ City/State: _____

What type of care are you interested in? ◊ Spinal Pain Relief ◊ Non-Spinal Pain Relief (i.e. knee, shoulder) ◊ Massage Therapy

Is today's visit due to a work related injury? ◊ Yes ◊ No Date of Injury: _____

Is today's visit due to an auto accident? ◊ Yes ◊ No Date of Injury: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Dear Patient: Please answer the questions truthfully and completely. Your answers will help us determine if chiropractic care can help you, and where to focus your examination. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU!

In general, would you say your health is (check one): ◊ Excellent ◊ Very Good ◊ Good ◊ Fair ◊ Poor

PAST HEALTH HISTORY:

1. **Have you ever experienced your present problem you are consulting us for previously?** ◊ Yes ◊ No

If yes, when? _____

Was treatment provided? ◊ Yes ◊ No If yes, by whom: _____ Outcome:_____

2. **Have you ever had a stroke or issues with blood clotting?** ◊ Yes ◊ No If yes, when? _____

3. **Have you recently experienced dizziness, unexplained fatigue, weight loss, or blood loss?** ◊ Yes ◊ No

If yes, when? _____

4. **Have you ever had any major illnesses, injuries, broken bones, hospitalizations, car accidents, or surgeries?**

Date:	Injury/Fracture/Illness/Accident/Surgery:	Treatment:	Results:

Please **CIRCLE** all symptoms you have ever had, even if they don't seem related to your current problem.

Headaches	Pain/Numbness in legs/feet	Neck Pain	Tension in the Neck
Back pain	Loss of balance	Dizziness	Stiff/Tight Neck
Ringing in the ears	Pain/Numbness in hands	Nervousness `	Carpal Tunnel
Migraines	Chronic Fatigue	Digestive Problems	Disc Problems
Depression	Irritability	Sleeping Problems	Diabetes
Lack of concentration	Mood swings	Bladder Problems	Prostrate Problems
Menstrual problems	High Blood Pressure	Asthma	Cardiovascular Ds.

Please explain any of the above YES answers:

_____

_____

Social History:

Recreational Activities/Hobbies: _____

Have these activities been limited by your pain? If yes, describe: _____

Yes No

◊ ◊ Do you exercise? _____ times/week

◊ ◊ Do you smoke/use tobacco? _____ packs/day (If you have quit smoking, when did you quit? _____)

◊ ◊ Do you consume alcohol? How many drinks per week? _____

◊ ◊ Do you eat a balanced diet? If no, explain: _____

◊ ◊ Do you get adequate sleep? How many hours per night:_____

◊ ◊ Is work stressful to you? If yes, explain: _____

◊ ◊ Is family life stressful to you? If yes, explain: _____

◊ ◊ Do you use recreational drugs? If yes, explain: _____

◊ ◊ Do you drink enough water daily? How much water do you drink per day? _____oz/day

◊ ◊ Do you consume caffeine? How much? _____oz/day

Current Health State:

1. On a scale of 1-10 rate your current state of health: Poor 1 2 3 4 5 6 7 8 9 10 Excellent

2. List your chief complaints in order of severity:

1. _____ For how long: _____

2. _____ For how long: _____

3. _____ For how long: _____

(Following questions refer to your #1 chief complaint)

3. What do you think is causing your chief complaint:_____

4. What makes it worse?_____

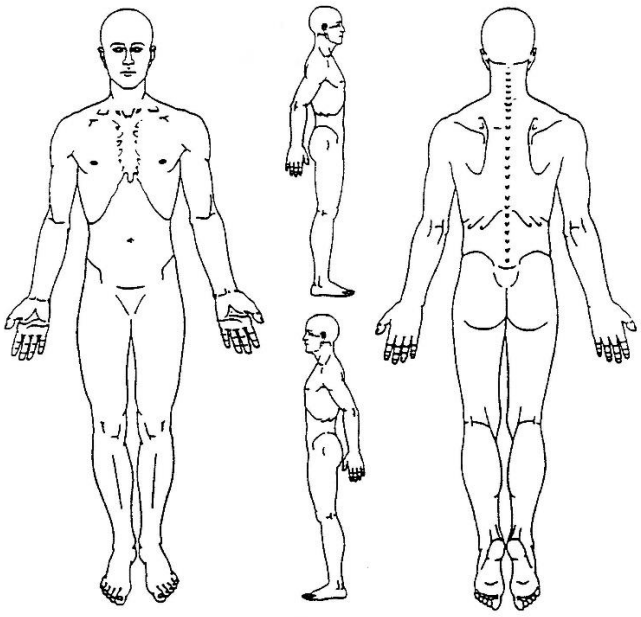
5. What seems to help it?_____

6. How often do you experience discomfort? □ Frequent □ On/Off □ Constant □ Never

7. Does the pain radiate: □ Yes □ No (If yes, where does it radiate)_____

8. Is your discomfort: □ Sharp □ Dull □ Burning □ Aching □ Come and Goes □ Constant

9. Since your problem started, is it... □ About the same □ Getting better □ Getting worse



Please mark areas of pain using these codes:

+++ Burning

Dull/Ache

*** Numbness/Tingling

=== Throbbing

000 Sharp/Stabbing

10. Does it interfere with: □ Work □ Sleep □ Hobbies □ Leisure □ Family Life

11. Rate your pain on a scale of 1-10 (10 being worst) 1._____ 2._____ 3._____

12. Are you wanting to patch up your problem or achieve more of a permanent solution if possible?_____

13. Other health care providers seen for this condition:_____

14. If the doctor identifies your spine to be misaligned, are you committed to follow the recommendations to correct your problem completely? □ Yes □ No

At Health Webb LLC we are not only interested in your health and well-being, but also the health and well-being of your family and friends. If you have friends and family members that would be interested in having any of their health conditions or concerns evaluated by a Wellness Chiropractor, please mention their name and number below:

Family Members: 1._____ 2._____

Friends: 1._____ 2._____

PAYMENT IS DUE AS SERVICES ARE RENDERED

All services are due when rendered, unless other arrangements have been made prior to treatment.

Method of payment: Cash: _____ Check: _____ Credit Card: _____

Personal Injury

While under care with Health Webb LLC if you become involved in a personal injury claim, please inform us immediately, so that we may take the proper steps to ensure that your case is addressed appropriately.

The information made on this form is accurate & I agree to allow this office to examine me for further evaluation:

Signature:_____ Date:_____

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