Discover Health & Wellness Northglenn New Patient History

Name:_____ Signature: _____

Date: _____

Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: ___/___/_____ Age: _____ **Circle One:** Married Single Other

Email Address: _____

Occupation: _____ Employer: _____ City of Employment: _____

Previous chiropractic care? **Circle One:** Yes No If yes, Name of doctor_____

How did you hear about the office? _____

1.) Do you have a main complaint? If yes, what is it?

_____

2.) When did you first notice your symptoms and what happened?

_____

3.) What aggravates your condition?

_____

4.) **Circle One**: Is your pain sharp or dull?

6.) Do you have any numbness, pins and needles? YES or NO If yes, where? _____

7.) Where is your pain located?

_____

8.) **Circle One:** Is your pain constant or comes and goes? How often? _____ _____

9.) Have you seen another doctor for this condition?

_____

10.) **Circle all that apply** | Do you have pain or problems with:

Jaw Hands Wrist Elbows Shoulder Hip Knees Ankles Feet

11.) Please list any prescriptions or supplements you have taken in the past six months:

_____

12.) When was your last car accident? _____

13.) Have you been hospitalized, had any injuries, or surgeries in the past 3 years?

_____

Circle all that apply | Does your family have a history of:

Arthritis Diabetes Hypertension Stroke Heart Disease Cancer