The contact information you provide us will be held in confidence and will only be used for documentation in your healthcare file and for contacting you regarding issues related to your care at New Hope Functional Chiropractic.

Name: _____Age _____

Date of Birth_____ Gender*(circle)* : Male Female

Mailing Address:_____City:_____

State _____ Zip Code _____ Home Phone # _____

E-Mail *(if applicable*) _____Cell Phone #_____

Work Phone #(*if applicable*)_____

How would you like us to contact you for appointment reminders? *(please circle)*

Home Phone/ E Mail /Cell Phone/ Work phone

Employer _____ Occupation _____

Spouse/Partner *(if applicable*): _____Phone:_____

Emergency Contact:_____Phone:_____

How were you referred to our office?:

(please circle) Website/ Newspaper article/ Seminar/Meeting/Advertisement

Another healthcare practitioner_____ Friend_____

Other _____

In general, please describe what concerns bring you into our office today:

_____

_____

_____

If so, how long ago did these symptoms begin? _____

If you are experiencing any pain or discomfort today, on a scale of 1 to 10 *(1 meaning "very mild" and 10 meaning "extremely severe")*, how would you describe your current symptoms?

☺ 1 2 3 4 5 6 7 8 9 10 ☹

Do you have any **allergies** or food sensitivities that you are aware of? Please describe:

_____

_____

Have you ever suffered a fracture or concussion, or have you been in an auto accident? Please describe:

_____

Please circle any surgical procedures you have experienced:

PROCEDURE	**DATE**	**PROCEDURE**	**DATE**	**OTHER (*Please list*)**
Tonsillectomy		Thyroid		
Gall bladder		Stomach		
Back Surgery		Knee		
Dental Surgery		Shoulder		
Female Organs		Foot		
Appendectomy		Rectal		
Hernia		Sinus		

*Please circle or **write in** symptoms that you are experiencing currently or in recent history:*

Energy and Mood	**Gastro-Intestinal**	**Eye/Ear/Nose/Throat**	**Respiratory**
Fatigue	Abdominal pain	Asthma	Chest pain
Anxiety or depression	Gas/bloating	Earache	Difficulty breathing
Poor concentration	Constipation	Hearing problems	Chronic cough
Sudden weight loss or weight gain	Diarrhea		Cold/hayfever/ congestion
Mood swings	Poor digestion	Sinus problems	
Sleep disturbances			
OTHER:	OTHER:	OTHER:	OTHER:

Genito-Urinary	**Musculo-skeletal**	**Cardio-Vascular**	**Skin/Allergies**
Bed wetting	Back pain	High blood pressure	Sensitive skin/skin eruptions
Frequent or painful urination	Foot/knee/shoulder or wrist pain	Chest pain	Psoriasis
Blood in urine/stool	Tremors/twitching	Strokes	Eczema
Prostate pain	Joint inflammation	Varicose veins	Bruise easily
OTHER:	OTHER:	OTHER:	OTHER:

Please list any prescription medications you are currently taking:

_____

_____

Please list any nutritional supplements (vitamins, minerals) you are currently taking:

_____

_____

_____

Have you ever been vaccinated? (please circle) YES/NO

If so, when were your most recent vaccinations (including flu vaccination)?

_____

_____

_____

Please share anything else you believe is relevant to your health concerns here:

_____

_____

_____

_____

Are you consulting any other healthcare practitioners for the concerns that brought you into our office today? (Please circle) YES/NO

If so, may we consult with him/her in order to better coordinate your care? (Please circle) YES/NO

Practitioner's Name and Telephone #

_____

The information on this document is true to the best of my knowledge.

_____/_____

Signature Date