NEW HOPE CHIROPRACTIC

309 S. West Ave Crooks, SD 57020

**Please provide your insurance card to the front desk during check in to ensure proper insurance filing.**

## Patient Information:

First: ______________________ MI: ________ Last: ______________________________

Date of Birth: ______________________________ Male/Female

Address: ____________________ City: _____________ State: _______ Zip: ____________

Home Phone: ____________________________ Cell Phone: ___________________________

Email (needed for health records access): ______________________________________

Can we send promotions/articles/new emails? ❒ Yes ❒ No

Occupation: ____________________________________________________________

Do you have any interest in losing weight and hearing about our weight loss program True Weight Solutions? ❒ Yes ❒ No

## Responsible Party:

Name: __________________________________________________________________

Relationship to Pt: _______________________________________________________

Phone: _________________________________________________________________

| Current Medications: | Previous Surgeries: |
|---|---|
| ________________ | ________________ |
| ________________ | ________________ |
| ________________ | ________________ |
| ________________ | ________________ |
| ________________ | ________________ |

Allergies: ______________________________

Height ____________ Weight ____________

**Circle one please**

Never Smoked

Former Smoker

Current Occasional Smoker

Current Daily Smoker

**Circle one please**

Never Married

Married

Divorced

Engaged

Widowed

Print Name: ______________________________

Date: ______________________________

MEDICAL HISTORY AND SYMPTOM / PAIN INFORMATION

Reason for today's visit:
[ ] New Injury [ ] Old Injury [ ] Chronic Pain [ ] Wellness

Are you in pain: Yes / No

Rate your pain with the following scale: (circle one)

None 1 2 3 4 5 6 7 8 9 10 Intense

WOMEN ONLY:
Are you pregnant? Yes / No How many months: __________

Symptoms you have experienced in the past 6 months:

- ❑ Low Back Pain
- ❑ Pain Between Shoulder Blade
- ❑ Neck Pain
- ❑ Tension/Migraine Headaches
- ❑ Tired/ Fatigued

- ❑ Tension Across Top of Shoulders
- ❑ Numbness/Tingling in Arms or Hands
- ❑ Numbness/Tingling in Legs or Feet
- ❑ Dizziness
- ❑ Ringing of Ears

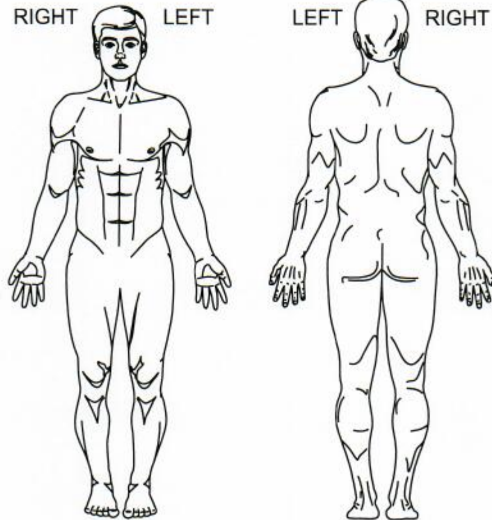
- ❑ Nervous
- ❑ Difficuity Sleeping
- ❑ Allergies
- ❑ Digestive Problems
- ❑ Weight Problems

- ❑ Other: ______________________________

PAIN DIAGRAM

Please complete the following "Pain Diegram" by using letters to indicate your areas of pain.

P. PAIN
T. TINGLING
N. NUMBNESS
B. BURNING
S. STIFFNESS




Initial Here ________

## Family History

*Please indicate any of the following conditions any immediate family members have or has had by placing (M) for mother, (F) for father, or (S) for sibling next to the condition.*

- ❒ Alcoholism
- ❒ Anemia
- ❒ Arteriosclerosis
- ❒ Arthritis
- ❒ Asthma
- ❒ Bleed Easily
- ❒ Cancer
- ❒ Diabetes
- ❒ Emphysema
- ❒ Epilepsy
- ❒ Glaucoma
- ❒ Heart Disease
- ❒ High Blood Pressure
- ❒ High Cholesterol
- ❒ Mutiple Sclerosis
- ❒ Osteoporosis
- ❒ Stroke
- ❒ Thyroid Disease