New Patient Information Form *Date: __________*

David McMullen, DC ☯ Chiropractic Health Centers, LLC ☯ Windsor Locks, Conn. 06096 ☯ ph:(860)627-5230 fax 627-9283

Patient Last Name	**First Name**	**M.I.**	**Ph:** cell ☐ home ☐	**How did you hear about us:** ☐ Sign ☐Yellow pages ☐ Dr.________________ ☐Other _________________

Patient Address	**City**	**State**	**Zip**	**Date of Birth (MM/DD/YY)**	**Age**	**Gender** ☐ M ☐ F

Patient SSN	**Insured Last Name**	**First Name**	**Relationship to Insured:** ☐ self ☐ spouse ☐ other____________

Employer Name	**Employer Town**	**Work Phone**	**Name of person to contact in case of emergency:** PH:

Is illness or injury related to: ☐ Work ☐ Auto ☐ Other	**Do you have other insurance that might cover this injury/ illness?** ☐ No ☐ Yes	**If yes, please list other insurance company name:** Secondary I.D.#:

Please list your reason(s) for this visit. List your condition(s) in order of importance:	**Approx. date you first noticed:**	**Using a scale in which "0" is no pain and "10" is severe pain, circle the number that best reflects your condition:** None…....…to...……Severe	**Please check the box that best reflects how much of the time you feel your pain or symptom(s) for the listed reason:** Sometimes / Occasionally / Frequently / Often
1. ____________________	__________	0 1 2 3 4 5 6 7 8 9 10	☐0-25% ☐26-50% ☐51-75% ☐75-100%
2. ____________________	__________	0 1 2 3 4 5 6 7 8 9 10	☐0-25% ☐26-50% ☐51-75% ☐75-100%
3. ____________________	__________	0 1 2 3 4 5 6 7 8 9 10	☐0-25% ☐26-50% ☐51-75% ☐75-100%
4. ____________________	__________	0 1 2 3 4 5 6 7 8 9 10	☐0-25% ☐26-50% ☐51-75% ☐75-100%

For each of the reasons or conditions listed above, please mark how it happened:

1. ☐ Developed over time ☐ Illness ☐ Injury ☐ Auto accident ☐ Other________________________________ ☐ I don't know
2. ☐ Developed over time ☐ Illness ☐ Injury ☐ Auto accident ☐ Other________________________________ ☐ I don't know
3. ☐ Developed over time ☐ Illness ☐ Injury ☐ Auto accident ☐ Other________________________________ ☐ I don't know
4. ☐ Developed over time ☐ Illness ☐ Injury ☐ Auto accident ☐ Other________________________________ ☐ I don't know

For each reason listed above, please check if it is better or worse with any of the following:

	HEAT better	**HEAT** worse	**COLD** better	**COLD** worse	**REST** better	**REST** worse	**ACTIVITY** better	**ACTIVITY** worse	**OTHER** better	**OTHER** worse	**(please describe on line below)**
Reason 1.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____________________
Reason 2.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____________________
Reason 3.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____________________
Reason 4.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	____________________

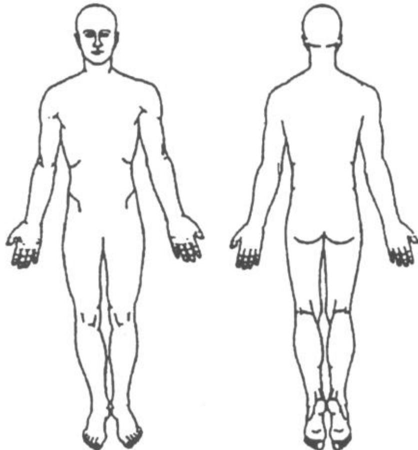
Please mark the areas of pain or discomfort on the figures using the symbols that best describe the feeling:

+++ Sharp or stabbing

OOO Pins and needles

VVV Dull or aching

/ / / Numbness



Please check the box that best describes whether your pain or symptom(s) limit normal activities:

Activity	**Normal**	**Somewhat limited**	**Severely limited**
Lifting	☐	☐	☐
Bending	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Sitting	☐	☐	☐
Climbing stairs	☐	☐	☐
Running	☐	☐	☐
Resting in bed	☐	☐	☐
Computer work/typing	☐	☐	☐
Normal work	☐	☐	☐
Household activities	☐	☐	☐
Recreational activities	☐	☐	☐
Other (list below)	☐	☐	☐
____________________	☐	☐	

Chiropractic Patient Information Form

Please continue…

a. During what time of the day do you feel worse? ☐ Morning ☐ Afternoon ☐ Evening ☐ Bedtime ☐ Other [explain]____________

b. Do you generally sleep well? ☐ Yes ☐ No What are your normal sleeping hours? _________to _________

c. Are you currently under the care of a medical doctor or other type of health care provider for any condition? ☐ No ☐ Yes ⇒ For what condition? _________________________Are you taking any medications? ☐ No ☐ Yes [please list]___________________

Name of your medical doctor/provider:______________________________ Phone # ( )_______-____________

d. Have you ever had an overnight stay in a hospital or a surgical procedure of any kind? ☐ No ☐ Yes If yes, please describe each event below:

Event____ Year:________

Event____ Year:________

e. Do you exercise? ☐ No ☐ Yes If yes, please describe activity:___________________________ How many days a week?_______

How many minutes per session?____ What activities would you like to do, but can't because of your condition?_______________

f. (FOR WOMEN)- IS THERE ANY CHANCE THAT YOU MAY BE PREGNANT? ☐ No ☐ Yes

Personal History

Please read through the list carefully and check the box next to any condition that applies to you.

Pain in body

☐ Neck pain with difficulty swallowing
☐ Extreme neck stiffness with pain or electric shocks in arms or legs when moving neck
☐ Leg pain that worsens with exercise but is relieved by resting
☐ Loss of feeling in inner thighs
☐ Back pain with urinary problems

Types of pain

☐ Severe pain interrupts sleep
☐ Constant pain that doesn't improve by changing positions or lying down

Current conditions

☐ Loss of balance when walking
☐ Recent unexplained weight loss
☐ Recent progressive muscle weakness or shaking
☐ Recent or current fever over 102^0F
☐ Loss of bowel or bladder control
☐ Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
☐ Recent major accident such as a fall from height, whiplash or blow to the head
☐ Memory loss after injury
☐ Night sweats

Previously diagnosed conditions/ medical history

☐ Rheumatoid arthritis
☐ Lupus
☐ Congenital bone or joint disorder
☐ Gout
☐ Severe degenerative arthritis
☐ History of compression fracture
☐ History of heart attack
☐ History of stroke or aneurysm
☐ Past history of cancer or currently diagnosed with cancer
☐ Diabetes w/ cold, burning or numb feet
☐ Ankylosing spondylitis
☐ Immune suppression such as from chemotherapy, organ transplant, etc.
☐ 3 or more months use of steroid medications or intravenous drugs (past or recent)

Family History

Please check the box next to each condition that either you or a family have, or have had in the past.

☐ Autoimmune disorders ☐ Arthritis ☐ Cancer ☐ Diabetes
☐ Heart Disease ☐ Kidney Disease ☐ Mental illness ☐ Seizure disorder

I certify that the above information is true and correct to the best of my knowledge. I hereby consent to the release of my confidential medical and patient information in the possession of the Chiropractic Health Centers, LLC to other health professionals to whom I am referred and to the insurance company or other entity responsible for payment, utilization and/or quality review for all or a portion of my care. Additionally, I authorize Dr. McMullen to receive any information acquired by examination or other means that is related to my physical condition, and I hereby release him of any consequence thereof. Furthermore, I assign benefits otherwise payable to me, to the Chiropractic Health Centers, LLC.. I understand that I am financially responsible for any co-pays, deductibles and balance not covered by my insurance.

Signature____ Today's Date:______/______/______