NEW PATIENT INFORMATION

Romney Chiropractic
turn over a new leaf in your health

Name _____ Today's Date_____

Date of Birth_____ Age ____ Sex: □ Male □ Female

Social Security # _____ Marital Status _____ Number of Children _____

Email _____ Home # _____ Work # _____

Cell # _____ Cell Provider (Verizon, T-Mobile,etc) _____

(Providing your cell provider allows us to send you appointment text reminders)

Address _____ City _____ Zip_____

Occupation _____ Employer _____ City_____

Type of work: □ Office/clerical □ Light Labor □ Moderate Labor □ Heavy Labor

Spouse Name _____ Spouse Date of Birth_____

Emergency Contact _____ Relationship _____ Phone _____

Name of person responsible for payment of this account _____

Have you ever received chiropractic care before? □ YES □ NO

If yes, how long ago?_____ For what?_____

How did you hear about our clinic? □ Friend, who_____ □ Sign □ Brochure
□ Doctor Referral,_____ □ Internet □ Health Insurance □ Other,_____

Goals of care: □ Symptomatic relief of pain or discomfort
□ Correct the cause of the problem
□ Improve function (ability to perform chores, job duties, play sports, enjoy hobbies)
□ Wellness and stress relief

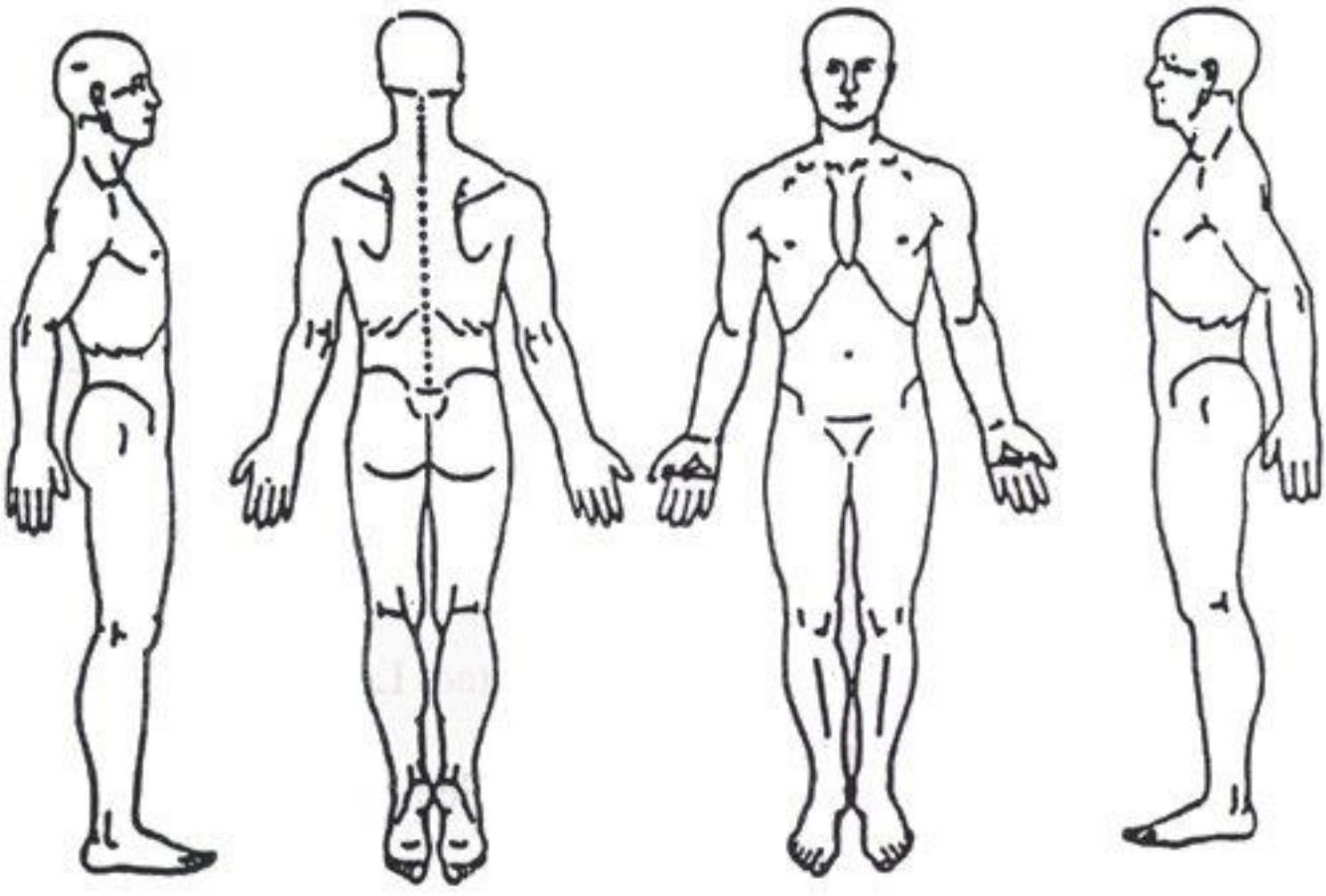
Continue with paperwork on next page

Please describe to the best of your knowledge, why you have your discomfort or pain:

BODY DIAGRAM

Please use the following symbols to mark the areas on the image below where you feel any described sensations

Dull Pain: NNN Stabbing/Cutting Pain: /// /// /// Burning: XXX Numbness: = = = Tingling: ::::: Cramping: SSS



CURRENT SYMPTOMS

Mark the boxes in column 1 and 3 if you have had any of these symptoms within the last 90 days

1.	Doctor's Notes	3.
□ Headache	□ Daily □ ____x/week D 1 2 3 4 F 1 2 3 4	□ Nervousness □ Anxiety
□ Neck Discomfort / Stiffness	□ Daily □ ____x/week D 1 2 3 4 F 1 2 3 4	□ Dizziness □ Light Headed □ Room Spinning □ Ear Ringing
□ Shoulder Discomfort / Stiffness	□ Daily □ ____x/week D 1 2 3 4 F 1 2 3 4	□ Difficulty Finding Comfortable Sleep Position □ Trouble Staying Asleep □ Trouble Falling Asleep
□ Arm / Hand discomfort	□ Daily □ ____x/week D 1 2 3 4 F 1 2 3 4	□ Fatigue □ Tiredness □ Irritability
□ Arm / Hand Numbness and/or Tingling	□ Daily □ ____x/week D 1 2 3 4 F 1 2 3 4	□ Nausea □ Vomiting
□ Chest / Rib Discomfort	□ Daily □ ____x/week D 1 2 3 4 F 1 2 3 4	□ Blurred Vision □ Double Vision
□ Upper Back Discomfort / Stiffness	□ Daily □ ____x/week D 1 2 3 4 F 1 2 3 4	□ Stuttering Speech □ Slurring Speech
□ Mid Back Discomfort / Stiffness	□ Daily □ ____x/week D 1 2 3 4 F 1 2 3 4	□ Change in Smell □ Change in Taste
□ Low Back Discomfort / Stiffness	□ Daily □ ____x/week D 1 2 3 4 F 1 2 3 4	□ Problems with coordination □ Poor Balance □ Dropping Things
□ Hip Discomfort	□ Daily □ ____x/week D 1 2 3 4 F 1 2 3 4	□ Light Sensitivity □ Noise Sensitivity
□ Leg / Foot discomfort	□ Daily □ ____x/week D 1 2 3 4 F 1 2 3 4	□ Increased Depression □ Increased Emotions
□ Leg / Foot Numbness and/or Tingling	□ Daily □ ____x/week D 1 2 3 4 F 1 2 3 4	□ Problems Finding the "right word", □ Difficulty with Math □ Difficulty Concentrating □ Difficulty with Names and Places
□ Jaw Discomfort	□ Daily □ ____x/week D 1 2 3 4 F 1 2 3 4	□ Other

Frequency (F1= 25%, F2= 50%, F3= 75%, F4=Constant) - Severity (D1= slight, D2=mild, D3=moderate, D4=severe).

Are you currently taking meds prescribed or over the counter for this condition? □ Yes □ No

If yes, describe:_____

List any healthcare providers, clinics, or therapists you have seen for this condition?

If you have not seen any healthcare provider for this condition then please check here ☐

And skip to the next page.

Name of provider/clinic	Special Tests (x-ray, MRI, etc)	Start Date & Stop Date	Type of Treatment and Medications prescribed	Results

PERSONAL HABITS & MEDICAL HISTORY

Do you drink alcohol? □ Yes □ No If yes, daily average _____

Do you drink coffee or tea? □ Yes □ No If yes, daily average _____

Do you drink soda/energy drinks? □ Yes □ No If yes, daily average _____

Have you smoked or used tobacco? □ Yes □ No If yes, how many years? _____ daily average now _____

How many hours of sleep per night? _____ How many hours of exercise per week? _____

How many vegetable servings daily? _____ How much water do you drink per day? _____

How old is your mattress? _____ Do you wear shoe inserts of foot orthotics? _____

What is your height? _____ What is your weight? _____ Are you pregnant? □ Yes □ No

Name of primary care doctor / Clinic _____City _____

Current medications: □ No □ Yes, _____

Previous Auto Accident? □ No □ Yes, _____

Serious Illness? □ No □ Yes, _____

Fracture/broken bone? □ No □ Yes, _____

Surgery? □ No □ Yes, _____

Work Injury? □ No □ Yes, _____

Sports Injury? □ No □ Yes _____

Other Injury? □ No □ Yes _____

If you have experienced any of the following conditions in the past mark a **"P"** in the box. If you are currently experiencing any of the following conditions please mark a **"C"**. (check all that apply)

	Heart attack		Prostate trouble		Arthritis		Gall bladder trouble
	Diabetes		Glaucoma		Fainting spells		Kidney stones
	Difficulty with urination		Bloody stools		AIDS		Asthma
	Stroke		Anemia		Constipation		Menstrual cramping
	Cancer		Ulcers		Diverticulosis		Shortness of breath
	Unexpected weight loss		Loss of memory		Chest pain		Sudden weight loss
	Gout		Diarrhea		General fatigue		Loss of hearing
	Nausea		Muscle cramping		Soreness in joints		Epilepsy
	Ears ringing		Headache		Migraine		Sprained ankle
	Dizziness		Tuberculosis		Syphilis		Concussion
	Knee/hip replacement		Broken bones				

In the last month, check if you have you had? □ unexpected weight loss □ viral / bacterial infection □ fever

□ difficulty with bowel movements □ difficulty with urination □ the "worst headache of your life"

□ **I have not had any of these things in the last month**

Do any family members (blood relatives) have these conditions? □ Diabetes □ Cancer □ Stroke

□ Heart Disease □ High BP □ Bleeding Disorder □ Neck/Low Back Pain □ Other, _____

PATIENT SIGNATURE: _____ **DATE:** _____