New Patient Enrollment Forms

Greetings,

At Optimum Health Chiropractic we take pride in the care for our patients. At every corner you will notice that we tailor to your needs and comfort. One of those ways is by making these forms available to you online. By making this packet available, we hope that this will reduce the wait time when visiting our clinic. Below you will find brief instructions on filing out this packet.

1. **Please fill out paperwork completely.**
2. **On the picture of the body, please put an "X" for pain and an "O" for numbness in the areas you are having trouble with.**
3. **List each complaint separately and as detailed as possible.**

Thank you very much for taking the time to fill these forms out before your first appointment and we also thank you for thinking of us when you are in need. We look forward to providing the absolute best care possible and exceeding your expectations!

Optimum Health Chiropractic Staff

WC	C	PI
MC	PR	BC

Date _____/_____/_____ File # _____

Name_____ Age____ Phone_____Cell_____Work_____
Street Address_____City_____State____Zip _____
Mailing Address _____
E-mail Address _____

Birth Date ____/____/____ Male / Female SS# _____-_____-_____
__Single __Married __Other Employed __Fulltime __Part-time __Student __Disabled
Occupation _____
Employer_____Address_____
Spouse's Name_____ Employer_____
Spouse's Birth Date ____/____/____ SS# _____-____-_____

Check any **Allergies**:
__Animals __Aspirin __Bees __Chocolate __Dairy __Dust __Eggs __Latex __Molds __Penicillin __Ragweed/Pollen __Rubber __Seasonal Allergies __Shellfish __Soaps __Wheat __X-Ray Dye __ Other_____

Check any **Surgeries**:
__Back __Brain __Elbow __Foot __Hip __Knee __Neck __Neurological __Shoulder __Wrist __Other:_____

Check **ALL Past Medical History** conditions:
__Ankle Pain __Arm Pain __Arthritis __Asthma __Back Pain __Broken Bones __Cancer __Chest Pain __Depression __Diabetes __Dizziness __Elbow Pain __Epilepsy __Eye/Vision Problems __Fainting __Fatigue __Foot Pain __Genetic Spinal Condition __Hand Pain __Headaches __Hearing Problems __Hepatitis __High Blood Pressure __Hip Pain __HIV __Jaw Pain __Joint Stiffness __Knee Pain __Leg Pain __Menstrual Problems __Mid-Back Pain __Minor Heart Problem __Multiple Sclerosis _Neck Pain __Neurological Problems __Pacemaker __Parkinson's __Polio __Prostate Problems __Shoulder Pain __Significant Weight Change __Spinal Cord Injury __Sprain/Strain __Stroke/Heart Attack __Other: _____

List all medications you are currently taking: _____

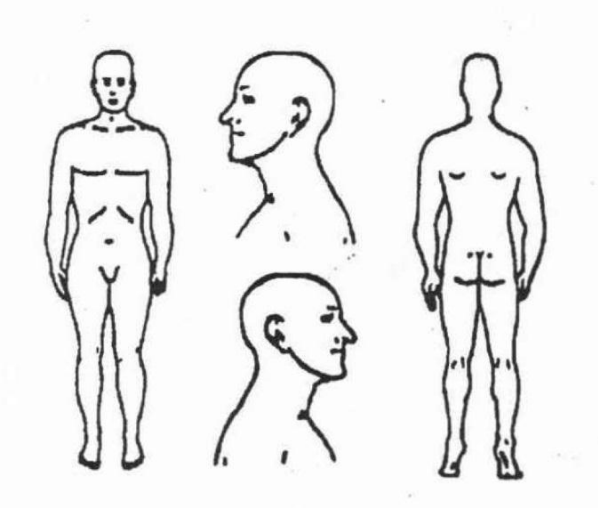
Person to Contact In Emergency	Name_____ Address_____Phone_____

Nearest Relative Not Living With You_____ Phone_____
Nearest Friend Not Living With You_____Phone_____
Physician_____ Phone_____

__CASH __CHECK __CREDIT CARD

Date of last physical examination: _____ Do you smoke? __No __Yes
Do you drink alcohol? __No __Yes – How many per day? _____
Do you drink caffeine? __No __Yes – How many per day?_____
Do you exercise? __No __Yes (what forms and how often): _____

Please mark ALL areas of **Pain** with a "X" Mark **Numbness** with an "O"



Main reason for consulting the office:
- __ Become pain free
- __ Explanation of my condition
- __ Learn how to care for my condition
- __ Reduce symptoms
- __ Resume normal activity level

What is your major complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? __GETTING BETTER __GETTING WORSE __NOT CHANGING

Have you had this condition in the past? YES / NO

How often do you experience your symptoms?

__Constantly (76%-100%) __Frequently (51%-75%)

__Occasionally (26%-50%) __Intermittently (0-25%)

Describe the nature of your symptoms: __Sharp __Dull __Numb __Burning __Shooting __Tingling __Radiating Pain __Tightness __Stabbing __Throbbing __Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

__1 __2 __3 __4 __5 __6 __7 __8 __9 __10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) __1 __2 __3 __4 __5 __6 __7 __8 __9 __10

What activities aggravate your condition (working, exercising, etc)? _____

What makes your pain better (ice, heat, massage, etc.)? _____

What is your SECOND complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? __GETTING BETTER __GETTING WORSE __NOT CHANGING

Have you had this condition in the past? YES / NO

How often do you experience your symptoms?

__Constantly (76%-100%) __Frequently (51%-75%)

__Occasionally (26%-50%) __Intermittently (0-25%)

Describe the nature of your symptoms: __Sharp __Dull __Numb __Burning __Shooting __Tingling __Radiating Pain __Tightness __Stabbing __Throbbing __Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

__1 __2 __3 __4 __5 __6 __7 __8 __9 __10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) __1 __2 __3 __4 __5 __6 __7 __8 __9 __10

What activities aggravate your condition (working, exercising, etc)? _____

What makes your pain better (ice, heat, massage, etc.)? _____

What is your THIRD complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? __GETTING BETTER __GETTING WORSE __NOT CHANGING

Have you had this condition in the past? YES / NO

How often do you experience your symptoms?

__Constantly (76%-100%) __Frequently (51%-75%)

__Occasionally (26%-50%) __Intermittently (0-25%)

Describe the nature of your symptoms: __Sharp __Dull __Numb __Burning __Shooting __Tingling __Radiating Pain __Tightness __Stabbing __Throbbing __Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

__1 __2 __3 __4 __5 __6 __7 __8 __9 __10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) __1 __2 __3 __4 __5 __6 __7 __8 __9 __10

What activities aggravate your condition (working, exercising, etc)? _____

What makes your pain better (ice, heat, massage, etc.)? _____