RWC
Riverside Wellness Center

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New Patient Questionnaire

Date_____

Name_____

Date of Birth _____

Address _____

City _____ State_____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

Marital Status: ☐Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Spouse Name _____

Your Occupation _____ Employer_____

Address _____

City _____ State_____ Zip_____

How were you referred to our office? _____

Person who holds primary health insurance, if other than yourself:

Name_____Date of Birth_____

Person who holds secondary health insurance, if other than yourself:

Name_____Date of Birth _____

Insurance Carrier _____

Physical

Please list your symptoms below in order of importance and give date symptoms began.

1.	Date
2.	Date
3.	Date
4.	Date

Is this condition due to an auto accident/injury? _____Yes ____No. If yes, list date of accident_____

Riverside Wellness Center
Name _____ Date _____

Please List all medications you are currently taking

Medication	Prescribed For:	How Long

Have you ever had the same or similar symptoms? _____ Yes ____No. If yes, when? _____

Have you had treatment by another doctor for these symptoms?_____ Yes __ No.

If yes, name of doctor_____

Is there any family history of this type of pain? _____ Yes ___ No.

Have you had any previous Chiropractic care? _____ Yes ___ No.

Have you ever been hospitalized? _____ Yes ___ No. If yes, when and why? _____

Have you ever broken any bones? ____ Yes ___ No. If yes, when and what? _____

_____

Have you noticed any recent changes in bowel or bladder habits? _____Yes_____No. If yes, please describe _____

Do you do aerobic exercise? _____ Yes ____ No Times/Week _____Minutes/Session _____

Do you do strengthening exercise? _____Yes ____No Times/Week_____ Minutes/Session _____

Do you currently smoke? _____ Yes _____ No Have you smoked in the past? _____Yes _____ No

Primary Care Provider

Doctor's name: _____ Phone #: _____

Office Address: _____

Fax: _____

RIVERSIDE WELLNESS CENTER

Name:_____ Date:_____

Diagnosis/Conditions

Please check the appropriate ***Y****es* or ***N****o* box for any of the following conditions/procedures which you have or have had previously. This is a confidential health report.

Y N Gastrointestinal
- ☐ ☐ Irritable Bowel Syndrome
- ☐ ☐ Inflammatory Bowel Disease
- ☐ ☐ Crohn's
- ☐ ☐ Ulcerative Colitis
- ☐ ☐ Gastritis or Peptic Ulcer Disease
- ☐ ☐ GERD (reflux)
- ☐ ☐ Celiac Disease

Other:_____

Y N Cardiovascular
- ☐ ☐ Heart Attack
- ☐ ☐ Stroke
- ☐ ☐ Elevated Cholesterol
- ☐ ☐ Hypertension (high blood pressure)

Other:_____

Y N Metabolic/Endocrine
- ☐ ☐ Type 1 Diabetes
- ☐ ☐ Type 2 Diabetes
- ☐ ☐ Hypoglycemia
- ☐ ☐ Metabolic Syndrome
- ☐ ☐ Hypothyroidism
- ☐ ☐ Hyperthyroidism
- ☐ ☐ Endocrine Problems
- ☐ ☐ Infertility
- ☐ ☐ Weight Gain
- ☐ ☐ Weight Loss
- ☐ ☐ Frequent Weight Fluctuations
- ☐ ☐ Bulimia
- ☐ ☐ Anorexia
- ☐ ☐ Eating Disorder (non-specific)

Other:_____

Y N Cancer
- ☐ ☐ Lung Cancer
- ☐ ☐ Breast Cancer
- ☐ ☐ Colon Cancer
- ☐ ☐ Ovarian Cancer
- ☐ ☐ Prostate Cancer
- ☐ ☐ Skin Cancer

Other:_____

Y N Genital and Urinary Systems
- ☐ ☐ Kidney Stones
- ☐ ☐ Gout
- ☐ ☐ Frequent Yeast Infections
- ☐ ☐ Erectile Dysfunction or Sexual Dysfunction

Other:_____

Y N Musculoskeletal/Pain
- ☐ ☐ Osteoporosis/Osteopenia
- ☐ ☐ Scoliosis
- ☐ ☐ Muscle Cramps
- ☐ ☐ Numb/Tingling
- ☐ ☐ Neck Pain
- ☐ ☐ Back Pain
- ☐ ☐ Joint Pain

Other:_____

Y N Inflammatory/Autoimmune
- ☐ ☐ Chronic Fatigue Syndrome
- ☐ ☐ Autoimmune Disease
- ☐ ☐ Rheumatoid Arthritis
- ☐ ☐ Lupus SLE
- ☐ ☐ Immune Deficiency Disease
- ☐ ☐ Poor Immune Function
- ☐ ☐ Frequent Infections
- ☐ ☐ Food Allergies
- ☐ ☐ Environmental Allergies
- ☐ ☐ Multiple Chemical Sensitivities
- ☐ ☐ Latex Allergy

Other:_____

Y N Respiratory Diseases
- ☐ ☐ Asthma
- ☐ ☐ Chronic Sinusitis
- ☐ ☐ Bronchitis
- ☐ ☐ Emphysema
- ☐ ☐ Pneumonia
- ☐ ☐ Tuberculosis
- ☐ ☐ Sleep Apnea

Other:_____

Y N Skin Diseases
- ☐ ☐ Eczema
- ☐ ☐ Psoriasis
- ☐ ☐ Acne
- ☐ ☐ Melanoma
- ☐ ☐ Skin Cancer: Type:_____

Other:_____

Y N Neurologic/Mood
- ☐ ☐ Depression
- ☐ ☐ Anxiety
- ☐ ☐ Bipolar Disorder
- ☐ ☐ Headaches
- ☐ ☐ Migraines
- ☐ ☐ ADD/ADHD

Y N Neurologic/Mood (continued)
- ☐ ☐ Memory Problems
- ☐ ☐ Parkinson's Disease
- ☐ ☐ Multiple Sclerosis

Other:_____

Preventative Tests and Date of Last Test

(*if known*)

Full Physical Exam:_____
Bone Density:_____
Colonoscopy:_____
Cardiac Stress Test:_____
EBT Heart Scan:_____
EKG:_____
Hemoccult Test-stool test for blood:_____
MRI:_____
CT Scan:_____
Upper Endoscopy:_____
Upper GI Series_____
Ultrasound:_____

Surgeries Dates

(if known)

Appendectomy:_____
Hysterectomy:_____
Gall Bladder:_____
Hernia:_____
Tonsillectomy:_____
Dental Surgery:_____
Joint Replacement Knee/Hip:_____
Heart Surgery – Bypass, Valve, Angioplasty, or Stent (*circle*):_____
Other:_____

Any other information:

_____
_____
_____
_____
_____
_____
_____