DESIGNED MOVE
CHIROPRACTIC & SPORTS REHABILITATION
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New Patient Information

Date:_____

First Name:_____ MI:___ Last Name:_____

DOB:_____ Age:_____ Sex:☐F☐M Height:_____ Weight:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email Address:_____ SS#:_____

Address:_____

City:_____ State_____ Zip: _____

Employer:_____

Work Address:_____

City:_____ State_____ Zip: _____

Occupation/Job Description:_____

Marital Status: ☐Married ☐Single ☐Domestic Partner ☐Widowed ☐Other: _____

Emergency Contact Name:_____

Relationship: _____ Phone:_____

Insured's Information

(ONLY FILL OUT IF PRIMARY HOLDER IS DIFFERENT FROM THE PATIENT)

First Name:_____ MI:___ Last Name:_____

Primary Phone:_____ _____SS#:_____ DOB:_____

Address:_____

City:_____ State_____ Zip: _____

Employer: _____ Work Phone: _____

Work Address:_____

City:_____ State_____ Zip: _____

Current Medication

(LIST ALL MEDICATION AND DOSAGE)

1._____ 2._____

3._____ 4._____

5._____ 6._____

7._____ 8._____

9._____ 10._____

Patient Name:_____ Date:_____

Past Health History

(CHECK IF YOU HAVE OR HAD ANY OF THE FOLLOW AND EXPLAIN WHERE INDICATED)

☐ Hospitalizations:_____

☐ Surgeries:_____

☐ Cancer If yes, type:_____ When:_____ In Remission? Y or N:___

☐ Rheumatoid Arthritis ☐ Systemic Lupus ☐ Psoriasis

☐ Arnold Chiari Malformation ☐ Marfan's/Ehler's Danlo Syndrome

☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Hyperthyroidism ☐ Hypothyroidism

☐ High Cholesterol ☐ Heart Attack ☐ Hypertension ☐ Stroke

☐ Arteriosclerosis ☐ Scoliosis

☐ Allergies/Intolerances _____

☐ Previous Injuries/Fractures:_____

☐ Accident History:_____

☐ Other:_____

☐ Previous Imaging (x-ray, MRI, CT, etc):_____

Family Health History

(PLACE A CHECK IN THE APPLICAPLE BOX & EXPLAIN WHERE INDICATED)

Relatives	Cancer (Type?)	Heart Disease	Stroke	Hyper-tension	Neurologic Disease (Type?)	Thyroid Disease	AutoImmune Disorder (Type?)	Arthritis (Type?)	Other?
Mother	☐	☐	☐	☐	☐	☐	☐	☐	
Father	☐	☐	☐	☐	☐	☐	☐	☐	
Sibling	☐	☐	☐	☐	☐	☐	☐	☐	
Grandparents	☐	☐	☐	☐	☐	☐	☐	☐	

Doctor/Office Use Only:

_____

_____

_____

_____

_____

_____

_____

Patient Name:_____ Date:_____

Review of Systems

(PLEASE INDICATE A NUMBER: "1"- PRESENTLY HAVE "2"- PREVIOUSLY HAD "3"- ACCIDENT RELATED)

General
___Allergy
___Chills
___Convulsions
___Dizziness
___Fainting
___Fatigue
___Fever
___Headache
___Sleep loss
___Weight loss/gain
___Nervousness/anxiety
___Neuralgia (nerve pain)
___Numbness
___Sweats
___Tremors
___Depression

Eyes, Ears, Nose, Throat
___Asthma
___Colds
___Sore throat
___Deafness
___Dental decay
___Earache/ringing
___Ear discharge
___Sinus infection
___Enlarged glands
___Enlarged thyroid
___Nose bleeds
___Failing vision
___Far sighted
___Near sighted
___Gum trouble
___Hoarseness
___Nasal obstruction

Musculoskeletal
___Arthritis
___Bursitis
___Hernia
___Low back pain
___Mid back pain
___Neck pain/stiffness
___Numbness/pain down the arms or butt/legs
___Arm pain
___Shoulder pain
___Leg pain
___Knee pain
___Foot pain
___Sciatica
___Spinal curvature
___Fractures

Genito-urinary
___Bedwetting
___Blood in urine
___Frequent urination
___Inability to control bladder
___Kidney infection/stones
___Painful urination
___Prostate issues
___Pus in urine

Women Only
___Painful menstruation
___Hot flashes
___Irregular cycle
___Lumps in breast
___Vaginal/nipple discharge
___Birth control pills
___Pregnancy complications

Cardiovascular
___High blood pressure
___Low blood pressure
___Heart disease
___Pain over heart
___Rapid heart rate
___Slow heart rate
___Poor circulation
___Swelling of ankles

Respiratory
___Chest pain
___Chronic cough
___Difficulty breathing
___Spitting up blood
___Spitting up phlegm
___Wheezing

Gastrointestinal
___Belching or gas
___Abdominal pain
___Constipation
___Diarrhea
___Difficult digestion
___Poor appetite
___Ulcers
___Vomiting
___Vomiting blood
___Abdominal bloating
___Excessive hunger
___Heartburn/reflux
___Hemorrhoids
___Jaundice/liver issues
___Nausea
___Gallbladder issues
___Colitis
___Irritable bowel syndrome

Doctor/Office Use Only:

Patient Name:_____ Date:_____

Lifestyle Habits

(PLEASE INDICATE A NUMBER 1-5: "1"- NO/NEVER "5"- YES/OFTEN)

1-5	Lifestyle Habit	Explain
	Exercise Regularly (3-5x/wk)	
	Smoking (packs/day)	
	Chewing Tobacco	
	Drinking Alcohol	
	Recreational Drugs	
	High Stress	
	Healthy Diet	

Current Physical Indicators Questionnaire

Have you ever experienced the following conditions? (check the box if "yes")

- ☐ Whiplash injury?
- ☐ Were you ever a smoker?
- ☐ Visual disturbances? (blurred, loss, double)
- ☐ Hearing disturbances? (loss, ringing)
- ☐ Slurred speech or other speech problems?
- ☐ Difficulty swallowing?
- ☐ Dizziness?
- ☐ Loss of consciousness/blackouts?
- ☐ Numbness, loss of sensation, strength/weakness?
- ☐ Sudden collapse without loss of consciousness?
- ☐ Unexplained weight loss/gain?
- ☐ Loss of bowel or bladder control?

Date(s) present:
From_____ To_____

Doctor/Office Use Only:

_____

_____

_____

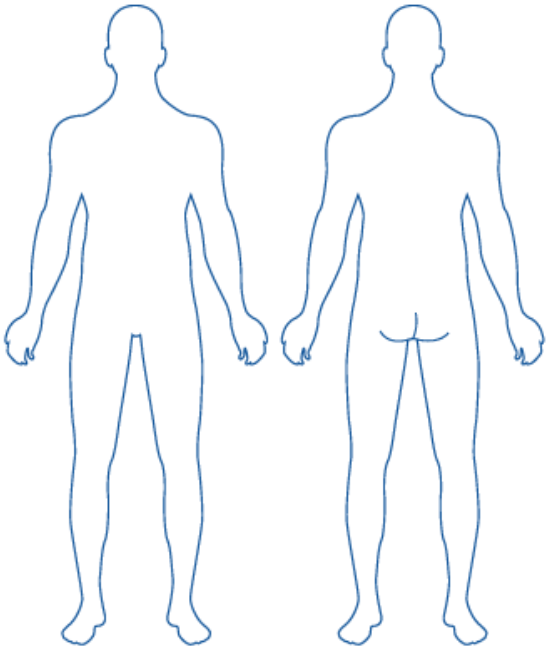
_____

Patient Name:_____ Date:_____

Current Condition

Using the symbols below, mark on the body the areas where you feel that particular sensation.

Numbness	Tingling	Burning	Aching	Sharp/Stabbing	Tightness
+++++	00000	XXXX	****	ssssss	/////



PAIN LEVEL

Please indicate you pain level 0-10
"0"- no pain; "10"- unimaginable pain

Current Pain
⊙0○1○2○3○4○5○6○7○8○9○10

Pain At Its Worst
⊙0○1○2○3○4○5○6○7○8○9○10

Typical Pain
⊙0○1○2○3○4○5○6○7○8○9○10

Reason for Appointment:

_____

_____

When did this begin?_____

Has it happened before? ☐ Yes ☐ No When? _____

How did this occur?

_____

_____

Since it began, has it: ☐ Improved ☐ Worsened ☐ Unchanged

What have you done for treatment/self treatment of this condition?

_____

What are your goals of care: ☐ Eliminate pain ☐ Improve overall health ☐ Prevent injury
☐ Improve nutrition ☐ Begin exercising ☐ Athletic performance ☐ Allergy testing
☐ Other:_____