

# WHITFORD CHIROPRACTIC CLINIC, P.C.

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## NEW PATIENT HISTORY

TODAY'S DATE \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex: M \ F  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (Home) \_\_\_\_\_ Phone (Work) \_\_\_\_\_ Marital Status: S M D W  
Spouse's Name \_\_\_\_\_ No. of Children \_\_\_\_\_ Occupation \_\_\_\_\_  
Social Security # \_\_\_\_\_ Email Address \_\_\_\_\_  
Is this a wellness check-up? Yes No Please indicate by an "X" how you feel today  
Referred by \_\_\_\_\_ 0 \_\_\_\_\_ 10

"Feel Great"

"Extremely Miserable"

Present complaint(s) in detail \_\_\_\_\_

When did it start? \_\_\_\_\_

What seems to make it worse? \_\_\_\_\_

What seems to make it better? \_\_\_\_\_

Is the complaint?: Sharp dull achy numbness

Other? \_\_\_\_\_

Is it constant or intermittent? \_\_\_\_\_

Yes / No Does the pain or discomfort seem to travel in your body?

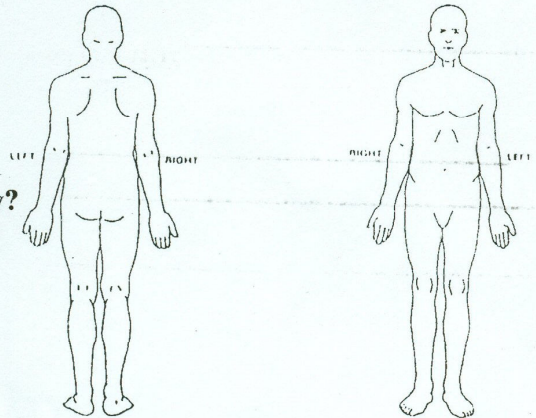
Where? \_\_\_\_\_

Yes / No Is today's visit due to a work related injury?

Yes / No Is today's visit due to an automobile accident?

Yes / No Have you other health problems, if so, what?

Please indicate where complaint is:



What immediate family health problems are there?

Yes / No Have you ever had any car accidents, falls, or surgeries?

Please describe \_\_\_\_\_

Yes / No Are you being treated by any other health care professional? Please describe treatment or medications \_\_\_\_\_

Yes / No Is this treatment helping?

Yes / No Have you seen a chiropractor before, who? \_\_\_\_\_

Yes / No Have you had recent spinal x-rays, when? \_\_\_\_\_

FOR WOMEN:

Yes / No Is there any chance that you may be pregnant?

When was the first day of your last normal menstrual period (LMP)? \_\_\_\_\_

Indicate how will you be paying for today's services. Cash / Visa/MC / Insurance contract (Please allow us to copy your drivers license and insurance card?)