

Newman Chiropractic Offices and WellQuest Wellness Center Case History/Patient Information

Name _____ Nickname _____

Address _____ City _____ State _____ Zip _____

E-Mail Address _____ Date of Birth _____ Age _____

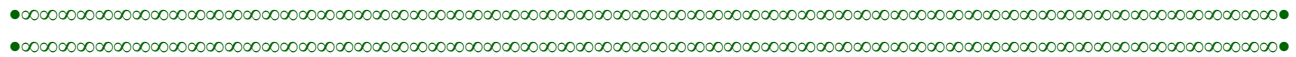
Social Security # _____ Occupation _____ Employer _____

H. Phone (____) _____ W. Phone (____) _____ Cell Phone (____) _____

Marital Status: S M D W Spouse's Name _____ Spouse's Occupation _____

Number of Children _____ Age(s) _____ Referral Source _____

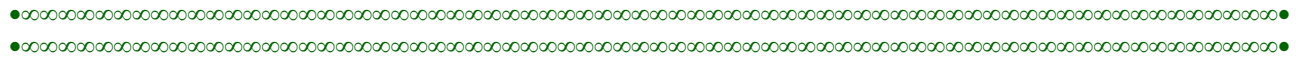
Have you ever received Chiropractic Care? Yes No



Please check yes or no to answer the following questions pertaining from age 5 through the present, and note any comments in the space provided:

Yes	No	Patient Comments:
<input type="checkbox"/>	<input type="checkbox"/>	Were you taught proper body movement and care? _____
<input type="checkbox"/>	<input type="checkbox"/>	Did/do you smoke? _____
<input type="checkbox"/>	<input type="checkbox"/>	Did/do you drink any alcohol? _____
<input type="checkbox"/>	<input type="checkbox"/>	Diet (Do you eat healthy foods)? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you been in accidents? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you had surgery and organs removed/replaced? _____
<input type="checkbox"/>	<input type="checkbox"/>	Drugs? (prescriptive or non-prescriptive) _____
<input type="checkbox"/>	<input type="checkbox"/>	Teeth problems? _____
<input type="checkbox"/>	<input type="checkbox"/>	Eye problems? _____
<input type="checkbox"/>	<input type="checkbox"/>	Hearing problems? _____
<input type="checkbox"/>	<input type="checkbox"/>	Exercise regularly? _____
<input type="checkbox"/>	<input type="checkbox"/>	Sleeping habits (nightmares)? _____
<input type="checkbox"/>	<input type="checkbox"/>	Did/do you have occupational stress? _____
<input type="checkbox"/>	<input type="checkbox"/>	Physical stress? _____
<input type="checkbox"/>	<input type="checkbox"/>	Mental stress? _____
<input type="checkbox"/>	<input type="checkbox"/>	Hobbies/sports injuries? _____
<input type="checkbox"/>	<input type="checkbox"/>	Other traumas or problems? _____

Sleeping posture Side Stomach Back



Have you been under drug and medical care? _____

What medications are you taking? _____

How long? _____ Have you had surgery? _____ What? _____ When? _____

What side effects have you experienced from the drugs and /or surgery? _____

Is there a family history of:	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

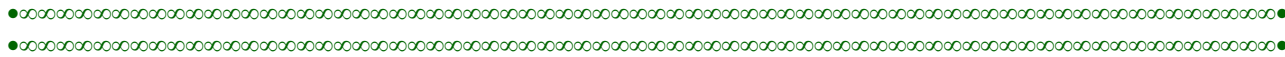
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Case History/Patient Information

What is your primary complaint? _____
 Pain or problem started on _____ Pains are: Sharp Dull Constant Intermittent
 What activities aggravate your condition/pain? _____
 What activities lessen your condition/pain? _____
 Is condition worse during certain times of the day? If yes, when? _____
 Is condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____
 Is condition getting progressively worse? _____
 Other doctors/remedies tried for this condition _____

Other symptoms:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Tension | <input type="checkbox"/> Irritability | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Pins & Needles In Legs |
| <input type="checkbox"/> Pin & Needles in Arms | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Loss of Memory |
| <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Fever | <input type="checkbox"/> Fainting | <input type="checkbox"/> Loss of Smell |
| <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Feet Cold | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Stomach Upset | <input type="checkbox"/> Constipation | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Buzzing in ears | | | |



Do you have Health Insurance? Yes No
 Name of Insurance Company _____ Phone Number _____
 Address of Insurance Company _____
 Name of Policy Holder _____
 SS or ID number of insured _____
 Policy Number/Group Number/Claim Number _____

Have you been in an accident? Yes No What type? Work Auto Other When? _____
 Nature of accident? _____ Did you feel popping or tearing in neck or back? _____
 Explain _____
 Were you hospitalized? _____ Where? _____ When? _____ Were x-rays taken? _____
 Have you lost days at work? _____ Dates missed: _____
 Is insurance involved? _____ Which company? _____ Claim # _____
 Insurance Address: _____