SPINE & JOINT ASSOCIATES

New Patient Information

Personal Information

Social Security Number: ______________________________ Patient Initials ________

Name: ______________________________ Date: __________ Age: _____ Male Female

How should we address you? ______________________________ Date of Birth: ________________

Race/Ethnicity: Caucasian Black Hispanic Asian Native American Other: ________________

Preferred Language: English Spanish Other: ________________

Marital Status: Single Married Divorced Widow Other__________ Number of Children: ________

Address: ______________________________ City: ________________ State: ______ Zip: ________

Home Phone: ______________________________ Cell Phone: ______________________________

Home Email: ______________________________ Work Email: ______________________________

I wish to receive email updates, specials and news from Spine and Joint Associates. Home email Work email

Employment Information

Employer: ______________________________ Occupation: ______________________________

Work Phone: ________________ Ext: ________ Fax: ______________________________

Emergency Contact Information

Name: ______________________________ Relationship: ______________________________

Home Phone: ________________ Cell Phone: ______________________________

Work Phone: ________________ Ext: ________

Please tell us about your condition

What is your major complaint? ____

How did this happen to you? ____

When did the symptoms for this condition/episode begin? ______________________________

Are your symptoms: Improving? About the same? Getting worse? Intermittent? (come and go)

Have you seen another medical professional for your condition? YES NO

Please specify: Medical Doctor Osteopath Physical Therapist Other: ______________________

Have you received Chiropractic care in the past? YES NO

How would you rate your past Chiropractic care? Excellent Good Average Below expectations

If this condition is work related, has it been reported to your employer? YES NO

~OVER~

SPINE & JOINT ASSOCIATES

Medical History Information

Name ____ Patient's Initials __________

Date ________________ Date of Birth ____________ Age ________ Male Female

Past Medical History

Hospitalizations	Year	Surgery/Illness	Hospital
1st			
2nd			
3rd			
4th			

Additional Major Illness: *Please check any that are applicable to you.*

Liver Bronchitis Depression Bowel Disease
Thyroid Asthma Cancer ________________________________
Coronary Artery Disease Emphysema/COPD Other ________________________________

Tests: *Please indicate the date when the following tests were last performed (month/year).*

Mammogram __________ Flu Shot ____________ Pelvic/Pap ____________ Prostate __________
Sigmoidoscopy ________ Rectal ______________ EKG ________________ Other ____________

Social History: *Please list necessary information when applicable.*

Tobacco (Cigarettes, Chew, Cigar, etc.) ____
Controlled Substances ____
Alcoholic Beverages ____
Live with ____
Live alone

Family History: *Please indicate illnesses your family members have currently or have had in the past.*

Father ____
Mother ____
Sister(s) ____
Brother(s) ____
Other ____

Previous Traumas, Falls, or Car Accidents: *Please list details including month/year.*

____
____

Medications: *Please list any medications you are currently taking and any allergies to medications you have. Indicate if the medication is prescription (Rx) or over the counter (OTC).*

1. ________________________________ Rx / OTC 4. ________________________________ Rx / OTC
2. ________________________________ Rx / OTC 5. ________________________________ Rx / OTC
3. ________________________________ Rx / OTC 6. ________________________________ Rx / OTC

Allergies to Medications ____

Physician:

Family Medical Physician ______________________________________ Phone ________________

Hospital ____

SPINE & JOINT ASSOCIATES

Review of Systems

Name ________________________________ Patient's Initials ___________

Date ________________ Date of Birth ____________ Age _________ Male Female

Constitutional Symptoms

Weight gain (within the last year) Fever Sleeping difficulty Hot flashes
Weight loss (within the last year) Chills Night sweats

Comments: ____

Eyes

Blurred vision Impairment Flashes Spots
Double vision Pain Discharge Itchiness
Loss of vision Redness Halo Contact Lenses

Comments: ____

Ears

Hearing Loss Abnormal Sounds Discharge Ringing
Pain Bleeding Motion sickness

Comments: ____

Mouth

Oral/Dental Problems Soreness Gum problems Bleeding
Swelling Ulcerations Palate Abnormal taste

Comments: ____

Cardiovascular

Surgical procedures Exertional Dyspnea Ankle swelling Nausea
Chest pain Shortness of breath Claudications Murmurs

Comments: ____

Respiratory

Past or Current Dx Chest pain Asthma Smoking Sputum
Cough Pain w/ deep breath Shortness of breath Wheezing Hemoptysis

Comments: ____

Gastrointestinal

Abdominal pain Hernia Diarrhea Heartburn
Irritable bowel Syndrome Bloating Bleeding/Black tarry stools Vomiting

Comments: ____

Genitourinary

Kidney Stones Last Pap ____________________ Breast problems
Surgeries Menopausal Symptoms Males: Prostate problems
STD's Menopause, age: ______________ Males: Testicular problems
Infections-discharge ____________ Menstrual cycles (pain, flow) Males: Decrease stream
Reproductive System history Last menstrual cycle: ___________ Urinary tract problems
(burning, frequency, incontinence)

~OVER~

Review of Systems

Patient Initials_______

Musculoskeletal

Skin rashes | Weakness of limbs | Edema (swelling) | Back problems/injuries
Deformities | Paralysis | Limitations of movement | Muscle spasms/cramps
Gout | Arthritis | Stiffness

Joint pain, location: ____

Joint grinding, location: ____

Comments: ____

Skin and/or Breasts

Hives | Bruise easily | Previous skin/Cellulitis | Surgical incisions scars
Oily skin | Eczema | Brittle nails | Rashes
Itching | Dryness | Lumps in skin/breasts | Moles with hair/change color
Change in color/hair texture/nail texture

Comments: ____

Neurological

Disequilibrium | Speech disorders | Seizures | Disorientation-memory loss
Tremors | Head injuries | Decrease in cognitive skills | Disorder of central nervous system
Confusion | Fainting | Headaches/pain in head | Syncope (loss of consciousness)

Numbness, location __________________

Comments: ____

Psychiatric

Anxiety | Palpations | Crying spells | Hallucinations
Change in appetite | Voices | Schizophrenic | Depression
Decrease in Libido (sex drive) | Shortness of breath | Quality/quantity of sleep | Anhedonia (absence of life pleasures)

Comments: ____

Endocrine

Hormonal imbalance | History of diabetes | Goiter | Polyuria (excessive urination)
Change in breasts | Sweating | Change in weight | Polyphagia (excessive eating)
Hot/cold tolerance | Fertility problems | Constipation | Breast/nipple discharge
Fatigue | Diarrhea | Thyroid problem | Polydipsia (excessive thirst)

Comments: ____

Allergic/Immunologic

Medicine allergies | Rashes | Hives | History of allergy testing
Wheezing | Joint swelling | Ear infections | Sinus problems-Rhinorhia
Food intolerance | Hay Fever | Postnasal drip | Red/Watery/discharge eyes
Asthma

Comments: ____

~OVER~