HealthSource Chiropractic
NEW PATIENT INFORMATION FORM

Please print clearly:

Name: _____ Date: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Shipping Address:

_____

_____

Home Phone (____) ____-_____ Work Phone (____) ____-_____

e-mail address: _____

REFERRED BY: _____

Occupation: _____ Employer: _____

Date of Birth: _____ Age: ____ Sex: F/ M Height: _____ Weight: _____

Overall health (circle one): Excellent / Good / Fair / Poor / Other: _____

Chief complaint (reason you are here): (use separate sheet if more room needed)

_____

Previous treatments for this complaint:

_____

_____

Other complaints or problems: (use separate sheet if needed):

_____

_____

Current medications/ drugs being taken: (use separate sheet if needed):

_____

_____

Are you currently under the care of a physician or other health care professionals?
(If yes, please give name and date of last visit):

_____

Nutritional supplements you are taking: _____

Do you smoke, drink coffee or alcohol? (If yes, indicate how much)

Cigarettes _____ Coffee _____ Alcohol _____

Office Use Only:

HealthSource Chiropractic
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Name: _____ Date: _____

HISTORY:

List any major illnesses (with approx. dates):

_____

_____

List any surgery or operations with approx. date:

_____

_____

Past Accidents or injuries:

_____

_____

Marital Status: Single Married Divorces Widowed Name of Spouse: _____

Describe health of spouse: _____ Number of children if any: _____

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	_____	M/F	_____
_____	_____	M/F	_____
_____	_____	M/F	_____
_____	_____	M/F	_____

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart

Other: _____

Any household pets or other animals you or family members are in close contact with:

_____

What can we do to make you happier?

_____

SIGNED: _____ DATE: _____

SYMPTOM SURVEY FORM

NAME _____ DOCTOR _____ DATE _____

AGE _____ SEX M ___ F ___

Phone # (_____) _____

INSTRUCTIONS: Number the boxes which apply to you with either a 1, 2, or 3
(1) for **MILD** symptoms
(2) for **MODERATE** symptoms
(3) for **SEVERE** symptoms
Leave the box **BLANK** if it does not apply to you!

GROUP 1

1 ☐ Acid foods upset
2 ☐ Get chilled, often
3 ☐ "Lump" in throat
4 ☐ Dry mouth-eyes-nose
5 ☐ Pulse speeds after meals
6 ☐ Keyed up - fail to calm
7 ☐ Cuts heal slowly
8 ☐ Gag easily
9 ☐ Unable to relax; startles easily
10 ☐ Extremities cold, clammy
11 ☐ Strong light irritates
12 ☐ Urine amount reduced
13 ☐ Heart pounds after retiring
14 ☐ "Nervous" stomach
15 ☐ Appetite reduced
16 ☐ Cold sweats often
17 ☐ Fever easily raised
18 ☐ Neuralgia-like pains
19 ☐ Staring, blinks little
20 ☐ Sour stomach frequent

GROUP 2

21 ☐ Joint stiffness after arising
22 ☐ Muscle-leg-toe cramps at night
23 ☐ "Butterfly" stomach, cramps
24 ☐ Eyes or nose watery
25 ☐ Eyes blink often
26 ☐ Eyelids swollen, puffy
27 ☐ Indigestion soon after meals
28 ☐ Always seems hungry; feel "lightheaded" often
29 ☐ Digestion rapid
30 ☐ Vomiting frequent
31 ☐ Hoarseness frequent
32 ☐ Breathing irregular
33 ☐ Pulse slow; feels "irregular"
34 ☐ Gagging reflex slow
35 ☐ Difficulty swallowing
36 ☐ Constipation, diarrhea alternating
37 ☐ "Slow starter"
38 ☐ Get "chilled" infrequently
39 ☐ Perspire easily
40 ☐ Circulation poor, sensitive to cold
41 ☐ Subject to colds, asthma, bronchitis

GROUP 3

42 ☐ Eat when nervous
43 ☐ Excessive appetite
44 ☐ Hungry between meals
45 ☐ Irritable before meals
46 ☐ Get "shaky" if hungry
47 ☐ Fatigue, eating relieves
48 ☐ "Lightheaded" if meals delayed
49 ☐ Heart palpitates if meals missed or delayed
50 ☐ Afternoon headaches
51 ☐ Overeating sweets upsets
52 ☐ Awaken after few hours sleeps - hard to get back to sleep
53 ☐ Crave candy or coffee in afternoons
54 ☐ Moods of depression - "blues" or melancholy
55 ☐ Abnormal craving for sweets or snacks

GROUP 4

56 ☐ Hands and feet go to sleep easily, numbness
57 ☐ Sigh frequently, "air hunger"
58 ☐ Aware of "breathing heavily"
59 ☐ High altitude discomfort
60 ☐ Opens windows in closed room
61 ☐ Susceptive to colds and fevers
62 ☐ Afternoon "yawner"
63 ☐ Get "drowsy" often
64 ☐ Swollen ankles worse at night
65 ☐ Muscle cramps, worse during exercise; get "charley horses"
66 ☐ Shortness of breath on exertion
67 ☐ Dull pain in chest or radiating into left arm, worse on exertion
68 ☐ Bruise easily, "black/blue" spots
69 ☐ Tendency to anemia
70 ☐ "Nose bleeds" frequent
71 ☐ Noises in head or "ringing in ears"
72 ☐ Tension under the breastbone, or feeling of "tightness", worse on exertion

GROUP 5

73 ☐ Dizziness
74 ☐ Dry Skin
75 ☐ Burning feet
76 ☐ Blurred vision
77 ☐ Itching skin and feet
78 ☐ Excessive falling hair
79 ☐ Frequent skin rashes
80 ☐ Bitter, metallic taste in mouth in mornings
81 ☐ Bowel movement painful or difficult
82 ☐ Worries, feels insecure
83 ☐ Felling queasy; headache over eyes
84 ☐ Greasy foods upset
85 ☐ Stools light-colored
86 ☐ Skin peels on foot soles
87 ☐ Pain between shoulder blades
88 ☐ Use laxatives
89 ☐ Stools alternate from soft to watery
90 ☐ History of gallbladder attacks or gallstones
91 ☐ Sneezing attaches
92 ☐ Dreaming, nightmare type bad dreams
93 ☐ Bad breath (halitosis)
94 ☐ Milk products cause distress
95 ☐ Sensitive to hot weather
96 ☐ Burning or itching anus
97 ☐ Crave sweets

GROUP 6

98 ☐ Loss of taste for meat
99 ☐ Lower bowel gas several hours after eating
100 ☐ Burning stomach sensations, eating relieves
101 ☐ Coated tongue
102 ☐ Pass large amounts of foul-smelling gas
103 ☐ Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
104 ☐ Mucus colitis or "irritable bowel"
105 ☐ Gas shortly after eating
106 ☐ Stomach "bloating" after eating

GROUP 7

(A)

107 ☐ Insomnia
108 ☐ Nervousness
109 ☐ Can't gain weight
110 ☐ Intolerance to heat
111 ☐ Highly emotional
112 ☐ Flush easily
113 ☐ Night sweats
114 ☐ Thin, moist skin
115 ☐ Inward trembling
116 ☐ Heart palpitates
117 ☐ Increased appetite without weight gain
118 ☐ Pulse fast at rest
119 ☐ Eyelids and face twitch
120 ☐ Irritable and restless
121 ☐ Can't work under pressure

(B)

122 ☐ Increase in weight
123 ☐ Decrease in appetite
124 ☐ Fatigue easily
125 ☐ Ringing in ears
126 ☐ Sleepy during day
127 ☐ Sensitive to cold
128 ☐ Dry or scaly skin
129 ☐ Constipation
130 ☐ Metal sluggishness
131 ☐ Hair coarse, falls out
132 ☐ Headaches upon arising wear off during day
133 ☐ Slow pulse, below 65
134 ☐ Frequency of urination
135 ☐ Impaired hearing
136 ☐ Reduced initiative

GROUP 7 (continued)

(C)

137 ☐ Failing memory
138 ☐ Low blood pressure
139 ☐ Increased sex drive
140 ☐ Headaches, "splitting or rending" type
141 ☐ Decreased sugar tolerance

(D)

142 ☐ Abnormal thirst
143 ☐ Bloating of abdomen
144 ☐ Weight gain around hips or waist
145 ☐ Sex drive reduced or lacking
146 ☐ Tendency to ulcers, colitis
147 ☐ Increased sugar tolerance
148 ☐ Women: menstrual disorders
149 ☐ Young girls: lack of menstrual function

(E)

150 ☐ Dizziness
151 ☐ Headaches
152 ☐ Hot flashes
153 ☐ Increased blood pressure
154 ☐ Hair growth on face or body (female)
155 ☐ Sugar in urine (not diabetes)
156 ☐ Masculine tendencies (female)

(F)

157 ☐ Weakness, dizziness
158 ☐ Chronic fatigue
159 ☐ Low blood pressure
160 ☐ Nails weak, ridged
161 ☐ Tendency to hives
162 ☐ Arthritic tendencies
163 ☐ Perspiration increase
164 ☐ Bowel disorders
165 ☐ Poor circulation
166 ☐ Swollen ankles
167 ☐ Crave salt
168 ☐ Brown spots or bronzing of skin
169 ☐ Allergies - tendency to asthma
170 ☐ Weakness after colds, influenza
171 ☐ Exhaustion - muscular and nervous
172 ☐ Respiratory disorders

FEMALE ONLY

173 ☐ Very easily fatigued
174 ☐ Premenstrual tension
175 ☐ Painful menses
176 ☐ Depressed feeling before menstruation
177 ☐ Menstruation excessive and prolonged
178 ☐ Painful breasts
179 ☐ Menstruate too frequently
180 ☐ Vaginal discharge
181 ☐ Hysterectomy/ovaries removed
182 ☐ Menopausal hot flashes
183 ☐ Menses scanty or missed
184 ☐ Acne, worse at menses
185 ☐ Depression of long standing

MALES ONLY

186 ☐ Prostate trouble
187 ☐ Urination difficult or dribbling
188 ☐ Night urination frequent
189 ☐ Depression
190 ☐ Pain on inside of legs or heels
191 ☐ Feeling of incomplete bowel evacuation
192 ☐ Lack of energy
193 ☐ Migrating aches and pains
194 ☐ Tire too easily
195 ☐ Avoid activity
196 ☐ Leg nervousness at night
197 ☐ Diminished sex drive

IMPORTANT

TO THE PATIENT: Please list below the five main health complaints you have in order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____

HealthSource Chiropractic

108 15th Ave E
Alexandria, MN 56308
320-762-1110

New Patient Introduction Form

Patient Name: Date:

1. Chief Concern:

2. Medications and/ or Nutritional Supplements currently on:

1. Dietary Intake for 2 days before appointment:

Breakfast:	Breakfast:
Snacks:	Snacks:
Lunch:	Lunch:
Snacks:	Snacks:
Dinner:	Dinner:
Snacks:	Snacks: