NEW PATIENT PAPERWORK

GENERAL INFORMATION:

NAME: _____ DATE OF BIRTH: ____/____/____ AGE: _____

HOME PHONE: _____ MOBILE PHONE: _____

EMAIL ADDRESS: _____ EMAIL REMINDERS? ☐ YES ☐ NO

GENDER AT BIRTH: (circle one): MALE / FEMALE

OCCUPATION: _____ EMPLOYER: _____

SOCIAL SECURITY#: _____ PREFERED NAME/NICKNAME: _____

MARTIAL STATUS (circle one): SINGLE / MARRIED / DIVORCED / SEPARATED / WIDOWED / OTHER

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMERGENCY INFORMATION:

EMERGENCY CONTACT NAME: _____

EMERGENCY CONTACT PHONE: _____ RELATIONSHIP: _____

FINANCIAL:

☐ SELF PAY

☐ INSURANCE

INSURANCE COMPANY: _____

INSURANCE ID #: _____ GROUP #: _____

PATIENT RELATIONSHIP TO INSURED: SELF / SPOUSE / PARENT / EMPLOYER / OTHER

NAME OF INSURED: _____

ADDRESS OF INSURED: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE OF INSURED: _____ SEX: MALE / FEMALE DATE OF BIRTH: ____/ ____/ _____

SECONDARY INSURANCE: ☐ YES ☐ NO

OTHER:

HOW DID YOU HEAR ABOUT US?

☐ SEARCH RESULTS/GOOGLE ☐ FACEBOOK or INSTAGRAM ☐ SIGN / DRIVING BY

☐ MAIL PROMOTION ☐ FRIEND/FAMILY – WHO? _____

☐ HEALTHCARE PROFESSIONAL – WHO? _____

LIFESTYLE (please check all that apply):

TOBACCO USE
- ☐ never smoked
- ☐ previous smoker
- ☐ less than 1 pack/day
- ☐ more than 1 pack/day
- ☐ more than 2 packs/day

ALCOHOL USE
- ☐ no alcohol use
- ☐ light alcohol use
- ☐ moderate alcohol use
- ☐ heavy alcohol use
- ☐ former alcohol use

ACTIVITY LEVEL
- ☐ sedentary lifestyle
- ☐ light physical activity
- ☐ moderate physical activity
- ☐ vigorous physical activity

MEDICAL HISTORY:

LIST ALL HOSPITALIZATIONS, SURGERIES, INJURIES AND ACCIDENTS AND DATES: _____

_____

_____

_____

LIST ANY OTHER INJURIES TO YOUR SPINE, MINOR OR MAJOR: _____

_____

_____

HAVE YOU EVER FRACTURED OR BROKEN A BONE? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE: _____

ALLERGIES: _____

_____

MEDICATIONS – list all prescription and over the counter medication you use and the reason for each:

_____

_____

_____

NUTRITIONAL SUPPLEMENTS: _____

_____

_____

FEMALES/PREGNANCIES (DATES OF EACH PREGNANCY and NUMBER OF CHILDREN): _____

_____

_____

PREVIOUS CHIROPRACTIC CARE? ☐ YES ☐ NO

IF YES, PLEASE LIST DATE, REASON FOR VISIT: _____

_____

PRIMARY CARE PHYSICIAN: _____

IS THIS VISIT A RESULT OF A RECENT ACCIDENT? ☐ YES ☐ NO

REVIEW OF SYSTEMS [check all that apply for past (**P**) or current (**C**)]:

GENERAL:

P	C		P	C		P	C	
☐	☐	Lethargy/Weakness	☐	☐	Recent weight loss/gain	☐	☐	Fever
☐	☐	Recurring Fever	☐	☐	Dizziness	☐	☐	Chills

HEAD, EYES, EARS, NECK, THROAT:

P	C		P	C		P	C	
☐	☐	Headaches or migraines	☐	☐	Eye or vision problems	☐	☐	Swollen glands
☐	☐	Eye or vision problems	☐	☐	Eye surgery	☐	☐	Nose/sinus congestion
☐	☐	Eyeglasses or contacts	☐	☐	Cataracts	☐	☐	Ear/hearing problems
☐	☐	Nose bleeds	☐	☐	Glaucoma	☐	☐	Dental problems
☐	☐	Eye surgery	☐	☐	Sore throat	☐	☐	TMJ problems
☐	☐	Cataracts	☐	☐	Hoarseness	☐	☐	Postnasal drip

SKIN / HAIR:

P	C		P	C		P	C	
☐	☐	Skin trouble or rashes	☐	☐	Psoriasis	☐	☐	Blood in stool
☐	☐	Flushing	☐	☐	Skin cancer	☐	☐	Easy bruising
☐	☐	Excessive acne	☐	☐	Skin pigmentation issues	☐	☐	Gum bleeding
☐	☐	Eczema	☐	☐	Change in hair or nails	☐	☐	Other: _____

CARDIOVASCULAR:

P	C		P	C		P	C	
☐	☐	Chest pain or tightness	☐	☐	High cholesterol/triglycerides	☐	☐	Leg pain upon walking
☐	☐	Heart attack	☐	☐	Heart murmur	☐	☐	Varicose veins
☐	☐	Shortness of breath	☐	☐	Blood clots	☐	☐	Dizziness
☐	☐	Palpitations	☐	☐	Pacemaker	☐	☐	Excessive bruising
☐	☐	Swelling of feet or hands	☐	☐	Mitral valve prolapse	☐	☐	Coronary artery disease
☐	☐	High blood pressure	☐	☐	Congenital heart defects	☐	☐	Other: _____
☐	☐	Low blood pressure	☐	☐	Rheumatic fever			

RESPIRATORY:

P	C		P	C		P	C	
☐	☐	Persistent cough	☐	☐	Sleep apnea	☐	☐	Breathing or lung problems
☐	☐	Spitting up blood	☐	☐	Emphysema	☐	☐	Hay fever
☐	☐	Asthma or wheezing	☐	☐	Snoring issues	☐	☐	Other: _____
☐	☐	Shortness of breath	☐	☐	Tuberculosis			
☐	☐	Exercise intolerance	☐	☐	Pneumonia			

GASTROINTESTINAL:

P	C		P	C		P	C	
☐	☐	Loss of appetite	☐	☐	Hemorrhoids	☐	☐	Change in bowel habits
☐	☐	Nausea or vomiting	☐	☐	Hepatitis	☐	☐	Black or bloody stool
☐	☐	Diarrhea	☐	☐	Cirrhosis	☐	☐	Colon cancer/colon polyps
☐	☐	Constipation	☐	☐	Difficulty swallowing	☐	☐	Food sensitivities
☐	☐	Abdominal pain	☐	☐	Jaundice	☐	☐	Irritable bowel syndrome
☐	☐	Stomach ulcer	☐	☐	Liver disease	☐	☐	Crohn's disease
☐	☐	Bloating/Cramping	☐	☐	Gallbladder problems	☐	☐	Gastric reflux
☐	☐	Heartburn	☐	☐	Pancreatitis	☐	☐	Colitis

NEUROLOGICAL:

P	C		P	C		P	C	
☐	☐	Frequent headaches	☐	☐	Pins and needles	☐	☐	Sleeping issues
☐	☐	Migraines	☐	☐	Epilepsy or seizures	☐	☐	Weak muscles
☐	☐	Dizziness	☐	☐	Stroke	☐	☐	Loss of smell or taste
☐	☐	Fainting	☐	☐	Tremors	☐	☐	Temporary loss of vision
☐	☐	Memory loss	☐	☐	Head injury	☐	☐	Difficulty concentrating
☐	☐	Poor balance	☐	☐	Anxiety and/or panic	☐	☐	Other: _____
☐	☐	Numbness or tingling	☐	☐	Depression			

MUSCULOSKELETAL:

P	C		P	C		P	C	
☐	☐	Arthritis	☐	☐	Scoliosis	☐	☐	Foot/ankle pain
☐	☐	Joint pain or swelling	☐	☐	Cramping	☐	☐	Shoulder problems
☐	☐	Neck pain	☐	☐	Fractures	☐	☐	Elbow/wrist pain
☐	☐	Back pain	☐	☐	Implants, plates, pins or screws	☐	☐	Poor posture
☐	☐	Trauma	☐	☐	Hip disorders	☐	☐	Gout
☐	☐	Osteoporosis	☐	☐	Knee injuries	☐	☐	Other: _____

BLOOD/LYMPH:

P	C		P	C		P	C	
☐	☐	Anemia	☐	☐	Past transfusions	☐	☐	Sickle cell
☐	☐	Bleeding	☐	☐	Leukemia	☐	☐	Other: _____
☐	☐	Bruising	☐	☐	Lymphoma			
☐	☐	Blood clots	☐	☐	HIV/AIDS			

ALLERGIES:

P	C		P	C		P	C	
☐	☐	Seasonal	☐	☐	Allergies to Medication: _____	☐	☐	Food Allergies: _____

PSYCHIATRIC:

P	C		P	C		P	C	
☐	☐	Alzheimer's Disease	☐	☐	Depression	☐	☐	Chemical dependency
☐	☐	Insomnia	☐	☐	Anxiety	☐	☐	Others: _____
☐	☐	Difficulty concentrating	☐	☐	Agitation/Irritability			
☐	☐	Memory loss/concentration	☐	☐	Suicidal thoughts			

ENDOCRINE:

P	C		P	C		P	C	
☐	☐	Diabetes	☐	☐	Weight gain	☐	☐	Hormonal changes
☐	☐	Thyroid problems	☐	☐	Frequent urination	☐	☐	Hyperparathyroidism
☐	☐	Sweating	☐	☐	Excessive thirst	☐	☐	Testosterone deficiency
☐	☐	Heat intolerant	☐	☐	Change in appetite	☐	☐	Cushing's syndrome
☐	☐	Cold intolerant	☐	☐	Hair changes	☐	☐	Steroid treatments
☐	☐	Weight loss	☐	☐	Hyperthyroidism	☐	☐	Other: _____

URINARY:

P	C		P	C		P	C	
☐	☐	Painful or frequent urination	☐	☐	Urgency	☐	☐	Urinary infections
☐	☐	Incontinence	☐	☐	Blood in urine	☐	☐	Genital/urinary complaints
☐	☐	Hesitancy	☐	☐	Kidney stones	☐	☐	Other: _____

REPRODUCTIVE:

P	C		P	C		P	C	
☐	☐	Painful sex	☐	☐	Discharge	☐	☐	Breast pain or lumps
☐	☐	Hot flashes	☐	☐	Menstrual irregularity	☐	☐	Loss of libido
☐	☐	Menopause	☐	☐	Sexually transmitted disease	☐	☐	Currently Pregnant
☐	☐	Dribbling	☐	☐	Erectile Dysfunction	☐	☐	Testicular Pain/Lumps
☐	☐	Prostate Disease	☐	☐	Other:_____			

REASON FOR VISIT:

LIST THE MAIN HEALTH CONCERNS THAT BROUGHT YOU INTO THIS OFFICE (in order of severity most to least):

1. _____
2. _____
3. _____

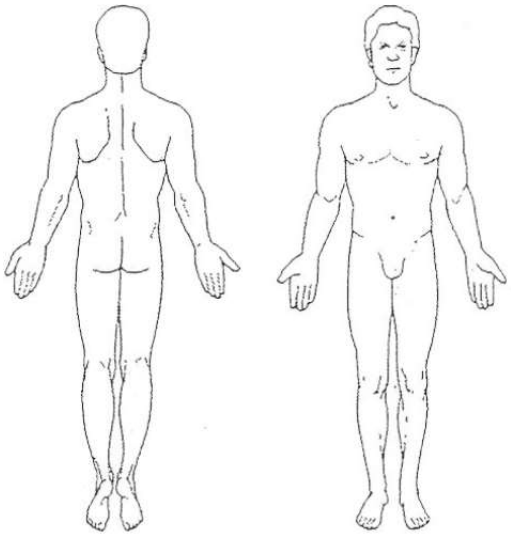
WHEN DID THIS BEGIN? ____ / ____/ ____ WHAT HAPPENED? _____

WHICH DAILY ACTIVITIES ARE BEING AFFECTED BY THIS CONDITION? _____

_____

HAVE YOU HAD THIS OR SIMILAR ISSUE IN THE PAST? IF YES, WHEN? _____

PLEASE CIRCLE OR MAKE AN "X" ON THE BODY DIAGRAM WHERE YOU HAVE PAIN OR SYMPTOMS:



ON THE SCALE BELOW, PLEASE CIRCLE THE SEVERITY OF EACH COMPLAINT AND LABEL EACH:

NO PAIN MODERATE PAIN WORST PAIN POSSIBLE

0	1	2	3	4	5	6	7	8	9	10

FREQUENCY: ☐ CONSTANT ☐ ON & OFF ☐ VARIES ☐ OTHER: _____

TIME OF DAY: ☐ MORNING ☐ AFTERNOON ☐ EVENING ☐ AS DAY PROGRESSES ☐ CONSTANT ☐ VARIES

QUALITY: ☐ SHARP ☐ STABBING ☐ BURNING ☐ ACHY ☐ DULL ☐ STIFF & SORE ☐ OTHER: _____

DOES IT RADIATE? ☐ YES ☐ NO IF YES, DESCRIBE THE PATH: _____

IMPROVES WITH: ☐ ICE ☐ HEAT ☐ MOVEMENT ☐ REST ☐ MEDICATION ☐ STRETCHING ☐ OTHER: _____

WORSENS WITH: ☐ SITTING ☐ STANDING ☐ WALKING ☐ LYING DOWN ☐ OVERUSE/LIFTING ☐ OTHER: _____

GOALS:

WHAT ARE YOU HEALTH RELATED GOALS? _____

_____

_____

_____

_____

I have answered these questions to the best of my knowledge and certify them to be true and correct.

I hereby authorize payment to be made directly to Roam Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Roam Chiropractic for any and all services I receive at this office.

PATIENT OR PARENT/GUARDIAN SIGNATURE: _____ DATE: ____/ ____ / _____