NYGREN CHIROPRACTIC & ACUPUNCTURE

NEW PATIENT FORM

Personal Information:

Name_____ DOB: _____ Age: _____ Sex: M F
Address_____City_____State_____Zip_____
Phone _____ Email: _____
Occupation:_____Work Duties:_____
Exercise routine:_____
Other recreational activities/hobbies?_____
Marital Status: S M D W Name of Spouse_____Number of children_____
Emergency Contact: Name_____Relationship_____Phone _____
Health Care Providers: Medical Doctor: _____ Last seen:_____
Previous Chiropractor: _____ Last seen:_____
Massage Therapist: _____ Last seen:_____
Acupuncturist/Other:_____ Last seen: _____

Present Condition:

Is this a personal Injury, auto accident or work related injury? Y N Involved in a lawsuit? Y N

Chief Complaint #1:_____ **Pain Level**: 1 (least) to 10 (severe) _____

This problem began: ☐ Gradually ☐ Suddenly Approx. Date: _____ Describe how: _____

_____

Treatments/tests run for this complaint & results:_____

_____

This problem is: ☐ constant ☐ comes & goes ☐ chronic ☐ severe ☐ intense ☐ mild ☐ nagging

Describe your condition: ☐ Sharp ☐ Dull ☐ Throbs ☐ Swells ☐ Cramps ☐ Numb ☐ Stiff

☐ Aches ☐ Shooting ☐ Burns ☐ Tingles ☐ Other_____

This problem occurs: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other_____

Activities that make it Worse circle W, make it Better circle B, make No Change circle NC:

Sitting: W B NC Standing: W B NC Walking: W B NC Bending: W B NC

Lying down: W B NC Work: W B NC Sleep: W B NC Daily routine: W B NC

Recreation/Exercise: W B NC Driving: W B NC Dressing: W B NC House Chores: W B NC

Yard Work: W B NC Other: _____

I would like the following treatment for complaint #1:

☐ Chiropractic ☐ Acupuncture ☐ Supplement Program ☐ Cold Laser ☐ Open to all

Chief Complaint #2:_____ **Pain Level**: 1 (least) to 10 (severe) _____

This problem began: ☐ Gradually ☐ Suddenly Approx. Date: _____ Describe how: _____

_____

Treatments/tests run for this complaint & results:_____

_____

This problem is: ☐ constant ☐ comes & goes ☐ chronic ☐ severe ☐ intense ☐ mild ☐ nagging

Describe your condition: ☐ Sharp ☐ Dull ☐ Throbs ☐ Swells ☐ Cramps ☐ Numb ☐ Stiff

☐ Aches ☐ Shooting ☐ Burns ☐ Tingles ☐ Other_____

This problem occurs: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other_____

Activities that make it Worse circle W, make it Better circle B, make No Change circle NC:
Sitting: W B NC Standing: W B NC Walking: W B NC Bending: W B NC
Lying down: W B NC Work: W B NC Sleep: W B NC Daily routine: W B NC
Recreation/Exercise: W B NC Driving: W B NC Dressing: W B NC House Chores: W B NC
Yard Work: W B NC Other: _____
I would like the following treatment(s) for complaint #2:
☐ Chiropractic ☐ Acupuncture ☐ Supplement Program ☐ Cold Laser ☐ Open to all

Case History:
Past accidents, falls, or injuries: _____
_____
Surgeries and hospitalizations with dates:_____
_____
Current prescription medications, vitamins & herbs and what they are for: _____
_____
_____

Family history of the same condition you have? Y N Family history of cancer, diabetes or heart illness? Y N Please list: _____

Females: Last menses: _____ Pregnant? Y N Trying for pregnancy? Y N

☑ What symptoms has your body been experiencing?

☑	Symptom:
☐	Acid Reflux
☐	Allergies
☐	Asthma/COPD
☐	Bladder Problems
☐	Cancer
☐	Depression
☐	Diabetes
☐	Diarrhea/Constipation
☐	Dizziness/Vertigo
☐	Epilepsy
☐	Fatigue/Fibro
☐	Fertility Issues
☐	Gallbladder

☑	Symptom:
☐	Gout
☐	Headaches
☐	Heart Condition
☐	Hepatitis
☐	High Blood Pressure
☐	High Cholesterol
☐	HIV
☐	Insomnia
☐	Joint Pains
☐	Kidney Problems
☐	Menopause Symptoms
☐	Menstrual Problems
☐	Night Sweats

☑	Symptom:
☐	Pacemaker
☐	Prostate Problems
☐	Skin Conditions
☐	Sleep Apnea
☐	Stomach Problems
☐	Stress!
☐	Stroke
☐	Thyroid Problems
☐	Tremors
☐	Vaccine Reaction
☐	Varicose Veins (Severe)
☐	Weight gain (unexplained)
☐	Other:

☑	Eating Habits:
☐	Caffeine—amount:
☐	Frequent Sugar (candy, cookies, donuts)
☐	Frequent Processed Foods (chips, boxed meals, etc)
☐	Artificial Sweeteners
☐	Soda—amount
☐	Energy Drinks—amount
☐	Frequent Fast Food
☐	4-8 Veggies/day
☐	1-3 Fruits/day
☐	6-8 glasses of water/day
☐	Special diet:
☐	

Please use the back page to hand write any other details you would like to include in your history.

Patient Signature: _____ Date: _____

Parent or Guardian Signature (if patient is under 18)_____ Date: _____