Creedmoor Wellness
Chiropractic • Acupuncture • Nutrition

New Patient Health Issues Information

Patient Name: _____ **Date:** _____

Problem 1:

When did it start? _____

Possible cause? _____

Is this problem getting: ☐ better ☐ worse ☐ constant

What makes it better? _____

What makes it worse? _____

Additional details?

_____

_____

_____

_____

Problem 2:

When did it start? _____

Possible cause? _____

Is this problem getting: ☐ better ☐ worse ☐ constant

What makes it better? _____

What makes it worse? _____

Additional details?

_____

_____

_____

_____

Problem 3:

When did it start? _____

Possible cause? _____

Is this problem getting: ☐ better ☐ worse ☐ constant

What makes it better? _____

What makes it worse? _____

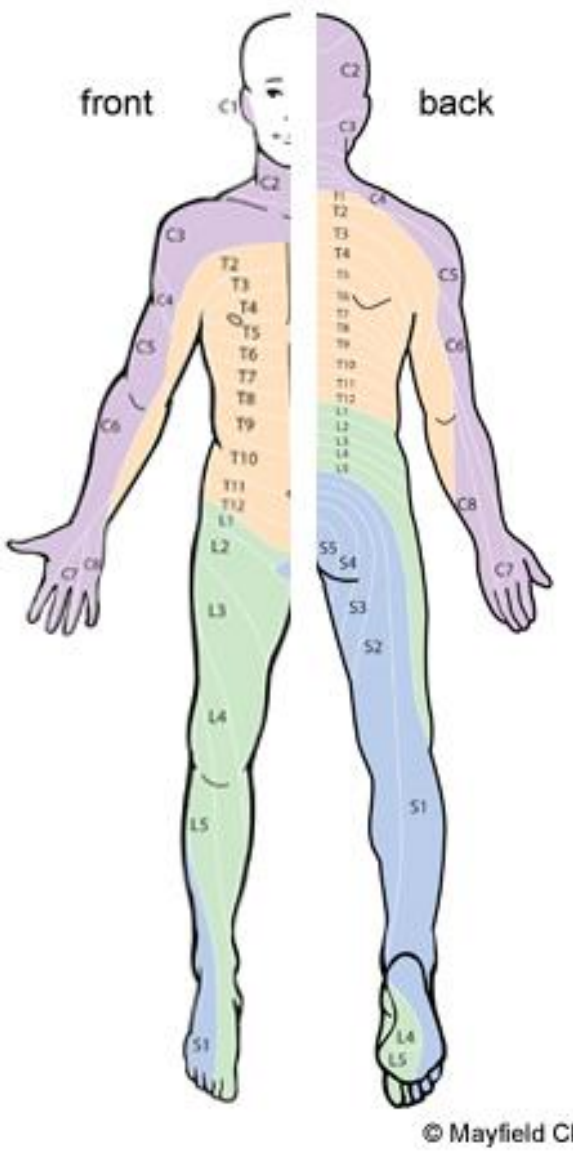
Additional details?

_____

_____

_____

_____



Please use the numbers on the body diagram above to indicate where and what type of symptoms you are experiencing. (Please also circle areas on the diagram above on printed form.)

Number of area on the above image: 1. _____ 2. _____ 3. _____

Severity of symptoms from list below: 1. _____ 2. _____ 3. _____

1-sharp 2-burning 3-dull ache 4-tingling

5-numb 6-stabbing 7-shooting 8-other

On a scale of 1-10 (1-least, 10-severe) how would you rate your

discomfort:

☐1 ☐ 2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Was the onset: ☐ sudden ☐ gradual ☐traumatic ☐unknown

What aggravates your symptoms:

☐ any movement ☐ going up stairs ☐ going down stairs ☐ sitting

☐ standing ☐turning ☐twisting ☐bending ☐ none ☐other

How often do you experience your symptoms?

☐ Constantly ☐ Frequently ☐Occasionally ☐Intermittently

☐ (76-100% of the day)

☐ (51-75% of the day)

☐ (26-50% of the day)

☐ (0-25% of the day)

Please list any surgeries that you have had. Please include dates if possible.

_____

_____

_____

_____

Have you ever broken any bones? ☐Y ☐N

If yes, what/when? _____

_____

_____

Have you been in any of the following types of accidents?

☐ auto accident ☐slip&fall ☐boating ☐motorcycle or bicycle ☐Other

List any details about any accidents:

_____

_____

_____

_____

Patient Social History and Health Habits

Please be honest! This information is confidential and very important!

Please answer all questions that apply completely, as some of these things can be very relevant to your current condition.

On a scale of 1-10 (1-least, 10-severe) how would you rate your normal stress level?

☐1 ☐ 2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

What causes you the most stress? (work, home, school, financial, other)

_____

_____

_____

Do you practice regular prayer or meditation? ☐Y ☐N

Please tell us about some of your hobbies:

_____

_____

_____

Do you exercise? ☐Y ☐N

If yes, what type and how often.

_____

_____

Please indicate your average use or consumption

Use of Type Quantity Frequency

Water _____ _____

Tobacco _____ _____

Alcohol _____ _____

Coffee _____

Sodas _____ _____

Sweets _____ _____

Tea _____ _____

Recreational Drugs _____ _____

Do you have specific food cravings? ☐Y ☐N

If yes, what are they?

☐ Sour ☐ Bitter _☐ Sweet ☐ Spicy ☐ Salty ☐ Other _____

When do they normally occur?

_____