Pathway Wellness Chiropractic Clinic

Tallahassee, FL

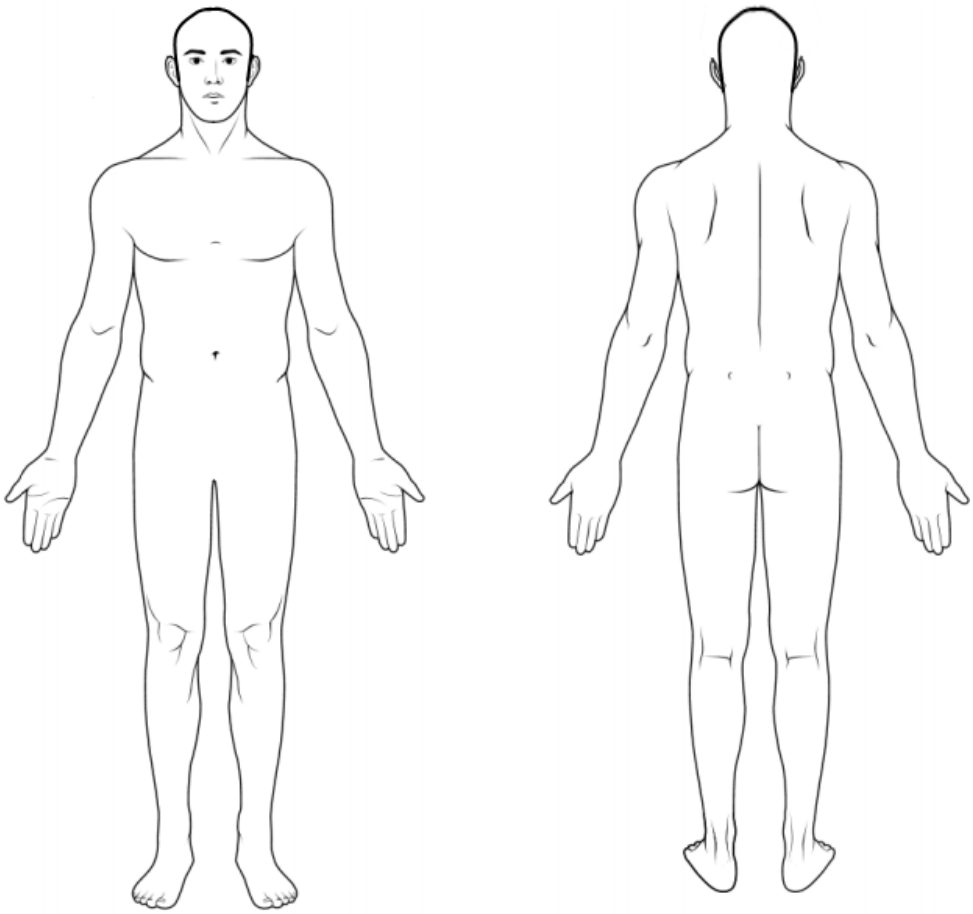
New Patient History Form

Last Name_____ First Name_____ Date_____
Last 4 of Social Security #_____ Birth Date_____
Address_____ City _____ State_____ Zip_____
Primary Phone Number: _____ Cell Phone Carrier: _____
Email Address_____
Primary Care Physician_____

Have you ever been to a chiropractor before? _____ If Yes: Where _____
For what condition? _____
How did you respond to treatment? _____

How did you hear about our clinic? _____
What type of insurance do you have CHP Blue Cross Aetna Other_____

Please Mark Your Areas of Pain on the Diagram Below



Type of Pain:

- Sharp/Stabbing
- Burning
- Ache
- Dull
- Numb/Tingling
- Other _____

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Section B *Please use a* **yes** *or* **no** *when answering any of the following. If you are not sure leave a* **?** .

___ Do you have a personal history of cancer?

___ Have you had any unexplained weight loss?

___ Recent trouble starting or stopping urination?

___ Recent trouble with bowel movements?

___ Numbness in the groin region?

___ Recent muscle weakness in the legs?

___ History of significant trauma?

___ Do you have osteoporosis?

___ History of prolonged use of corticosteroids?

___ Do you have a connective tissue disorder?

___ Current or recent infection?

___ History of immunosuppression medication &/or condition?

___ Do you have hypertension?

___ Do you smoke?

PAST HISTORY

PREVIOUS INJURIES *(Please give dates, describe injury and care received***)**

AUTO: _____
_____

WORK RELATED: _____
_____

PERSONAL: _____
_____

LIST ALL SURGERIES: _____
_____

CURRENT MEDICAL CONDITIONS: ie. (diabetes, high blood pressure, high cholesterol, etc)
_____
_____

LIST ALL MEDICATIONS/VITAMINS:
_____
_____

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REVIEW OF SYSTEMS

Please use the numbers below when answering. If you have never had the condition, please leave blank.

1. Current
2. Related to auto accident

GENERAL SYMPTOMS
___784.0 Headache
___780.6 Fever
___780.99 Chills
___780.8 Night Sweats
___780.2 Fainting
___780.4 Dizziness
___780.7 Fatigue
___799.2 Nervousness
___783.0 Loss of Weight
___782.0 Numbness or pain in arms/legs/hands

MUSCLE & JOINTS
___728.9 Weakness
___723.5 Stiff Neck
___724.5 Backache
___719.0 Swollen Joints

GASTRO-INTESTINAL
___787.0 Nausea
___787.0 Vomiting
___578.0 Vomiting Blood
___564.0 Constipation
___787.91 Diarrhea

CARDIO VASCULAR
___401.9 High Blood Pressure
___458.9 Low Blood Pressure
___429.9 Heart Trouble
___719.07 Swelling Ankles
___459.9 Poor Circulation
___454.9 Varicose Veins
___436.0 Strokes

EYE/EAR/NOSE/THROAT
___368.9 Poor Vision
___379.91 Pain in Eyes
___388.70 Earache
___388.30 Ear Noises
___784.7 Nose Bleeds

SKIN/ALLERGIES
___924.9 Bruising Easily
___782.0 Sensitive Skin
___708.9 Hives or Allergies
___692.9 Eczema

RESPIRATORY
___786.2 Chronic Cough
___786.2 Spitting Blood
___786.5 Chest Pain
___786.09 Difficult Breathing

GENITO-URINARY
___788.1 Painful Urination
___599.7 Blood in Urine
___590.0 Kidney Infection
___788.3 Inability to control urine

Other conditions not listed above:

_____

_____

_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

_____Date_____

Signature of patient (or parent of minor)