

# Pathway Wellness Chiropractic Clinic

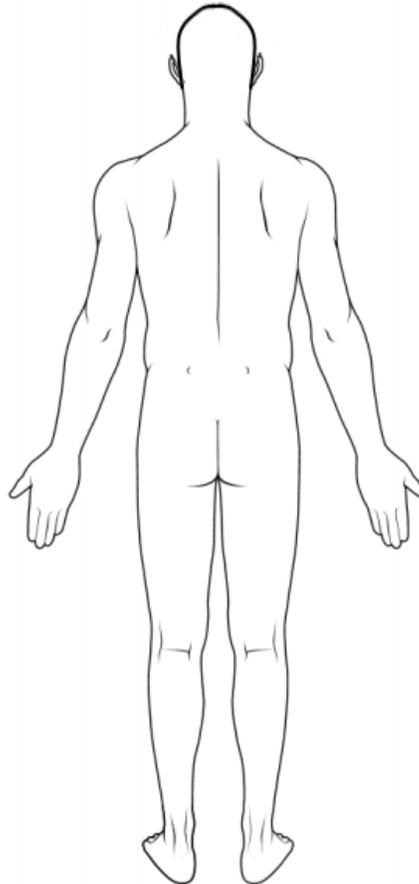
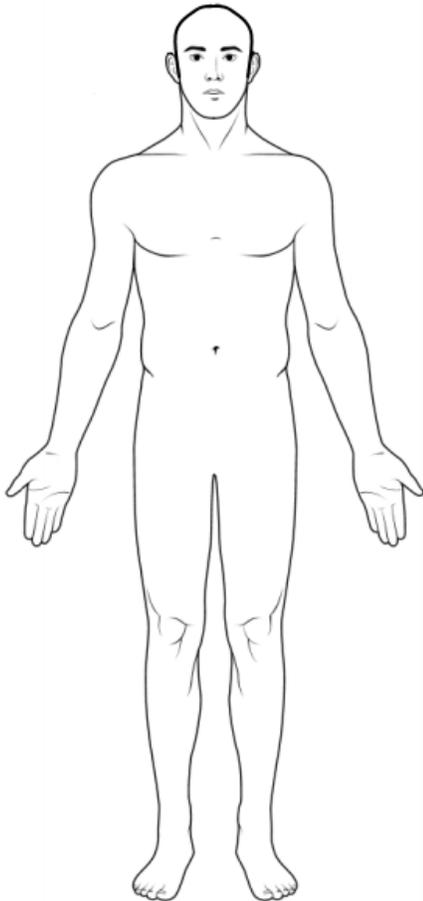
Tallahassee, FL

## New Patient History Form

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date \_\_\_\_\_  
Last 4 of SSN \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Primary Phone Number \_\_\_\_\_ Cell Phone Carrier \_\_\_\_\_  
Email address \_\_\_\_\_  
Car Insurance \_\_\_\_\_ Claim # \_\_\_\_\_  
Name of your attorney \_\_\_\_\_

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**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 ? .

- |   |  |
|---|--|
| <input type="checkbox"/> Do you have a personal history of cancer?      | <input type="checkbox"/> Do you have osteoporosis?                               |
| <input type="checkbox"/> Have you had any unexplained weight loss?      | <input type="checkbox"/> History of prolonged use of corticosteroids?            |
| <input type="checkbox"/> Recent trouble starting or stopping urination? | <input type="checkbox"/> Do you have a connective tissue disorder?               |
| <input type="checkbox"/> Recent trouble with bowel movements?           | <input type="checkbox"/> Current or recent infection?                            |
| <input type="checkbox"/> Numbness in the groin region?                  | <input type="checkbox"/> History of immunosuppression medication &/or condition? |
| <input type="checkbox"/> Recent muscle weakness in the legs?            | <input type="checkbox"/> Do you have hypertension?                               |
| <input type="checkbox"/> History of significant trauma?                 | <input type="checkbox"/> 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:

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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)** \_\_\_\_\_