SHINE
center for wellbeing

New Patient History Form

Name_____ Date_____

Address_____ SSN_____

City/State/Zip_____

Phone: Home_____ Cell_____ Work_____

Email address_____

Age_____ Date of birth_____ Sex: M F Marital status: S M D W

Name of spouse/partner_____

Names and ages of children_____

Occupation_____ Employer_____

How did you hear about us?_____

What is your reason for seeking care with us?_____

Please rate yourself in the following categories—0 being *poor* and 5 *excellent*:

0 1 2 3 4 5 Overall physical health
0 1 2 3 4 5 Emotional/mental health
0 1 2 3 4 5 Overall quality of life
0 1 2 3 4 5 Ability to deal with and adapt to stress

How much stress is in your life—0 being *very little* and 5 *very much*? 0 1 2 3 4 5

Y N Have you ever been to a chiropractor or other nervous system specialist? If yes, list name(s) and method/technique used, if you know._____

Y N Do you have a primary care physician? Name:_____

Y N Do you consult him/her regularly? If so, for what reason?_____

Date of last medical consultation._____

Have you ever been diagnosed or treated for any of the following conditions?

❑ Aids/HIV ❑ Allergies ❑ Anxiety ❑ Arthritis
❑ Cancer ❑ Depression ❑ Diabetes ❑ Heart disease
❑ Scoliosis ❑ Stroke ❑ Teeth grinding ❑ TMJ
❑ Other_____

Please explain with dates._____

Y N Has anyone in your immediate family ever suffered a serious mental or physical illness?

If so, please list relative and illness._____

History of Emotional Stress

Each of life's stresses is a potential cause of tension in the spine/nervous system. Rate the severity of each below—0 being the *least* severe and 5 the *most*:

0 1 2 3 4 5 Abuse
0 1 2 3 4 5 Divorce/separation
0 1 2 3 4 5 Friends
0 1 2 3 4 5 Work
0 1 2 3 4 5 Parents' divorce
0 1 2 3 4 5 Other
0 1 2 3 4 5 Childhood
0 1 2 3 4 5 Family
0 1 2 3 4 5 Illness
0 1 2 3 4 5 Job loss
0 1 2 3 4 5 School
0 1 2 3 4 5 Commuting
0 1 2 3 4 5 Financial
0 1 2 3 4 5 Illness of loved one
0 1 2 3 4 5 Loss of a loved one
0 1 2 3 4 5 Lifestyle change

Description and comments._____

_____

For women only:

Y N Are you pregnant? Date of last monthly period._____

Y N Are your periods painful? Please describe what your monthly cycle is like (pain-free, regular, painful with cramping, irreguar, etc)._____

Y N Have you ever been pregnant? If yes, note number and dates._____

What were your pregnancies like? Please check all boxes below that apply to any of your births.

❑ Breech ❑ Caesarian ❑ Forceps ❑ Epidural

Y N Are you are in menopause or peri-menopause? If so, please describe what you are experiencing.

_____

History of Physical Stress

Y N Have you ever sustained any head injuries?

Y N If so, were you knocked unconscious?

If yes, please explain with dates._____

Y N Have you been in any of the following accidents? ❑ Auto ❑ Motorcycle ❑ Bicycle

Describe with dates:_____

_____

Y N Have you ever broken any bones? If yes, list with dates._____

_____

What other injuries have you had? Please list and describe with dates._____

_____

Y N DK Were there any difficulties associated with your mother's pregnancy or your birth?

If yes, please describe._____

Of the activities below, which you do regularly at work, home, or school?

❑ Exercise ❑ Lift ❑ Reach ❑ Stand

❑ Sit ❑ Use computer ❑ Use phone

Have you had any of the following medical interventions?

❑ Cast/collars ❑ Chemotherapy ❑ Hospitalization ❑ Organ removal

❑ Physiotherapy ❑ Shoe lifts ❑ Surgery ❑ Spinal tap

❑ Traction ❑ X-ray therapy—extensive ❑ Other_____

Explain with dates._____

Y N Do you, or have you, served in the armed forces? If so, list dates._____

History of Chemical Stress

Y N Have you been vaccinated?

Y N Are you currently taking any of the following?

❑ Over-the-counter medication ❑ Prescription medication ❑ Vitamins ❑ Herbs

Do you regularly consume any of the following?

❑ Alcohol ❑ Artificial sweetener ❑ Caffeine ❑ Meat

❑ Recreational drugs ❑ Refined sugar ❑ Tap water ❑ Tobacco

❑ Other_____

Description/comments._____

Do you currently, or have you ever, worked with any of the following?

❑ Chemicals ❑ Fumes ❑ Smoke

Y N Is there anything else you would like to share which may help us to better understand you, and why you have chosen to come to this office?_____

_____

_____

Signature_____Date_____