1511 W Hwy 24 Wamego KS 66547 | Phone: (785) 456-2046 | Fax: (785) 456-2048 | **Complete Care Chiropractic LLC**

New Patient Form

Last Name:_____ **First Name:**_____ **Middle Initial:**_____

Address:_____ **Apartment #:**_____

City:_____ **State:**_____ **Zip:**_____

Primary Phone#:_____ **(Home / Cell)**

Secondary Phone#:_____**(Home / Cell)**

Email:_____

Date of Birth:_____/_____/_____ **Gender: (circle one): Male Female Marital Status (circle one): S M D W**

If married, name of Spouse: _____ **Currently pregnant? Yes/No # of Children:** _____

Were you referred to our office? If so, how/ by whom? _____

Status: Employed/ Unemployed/ Retired/ Student/ Other Occupation:_____

Employer:_____ **Work #:**_____ **Ext:**_____

Emergency Contact:_____ **Relationship:**_____ **Phone#:**_____

Primary Care Physician (PCP**):**_____ **Phone#**(PCP)**:**_____

Patient Signature*:** _____ ***Date:_____

Guardian Signature: _____ ***Date:***_____

Height:_____ Weight: _____ Blood Pressure:_____/_____

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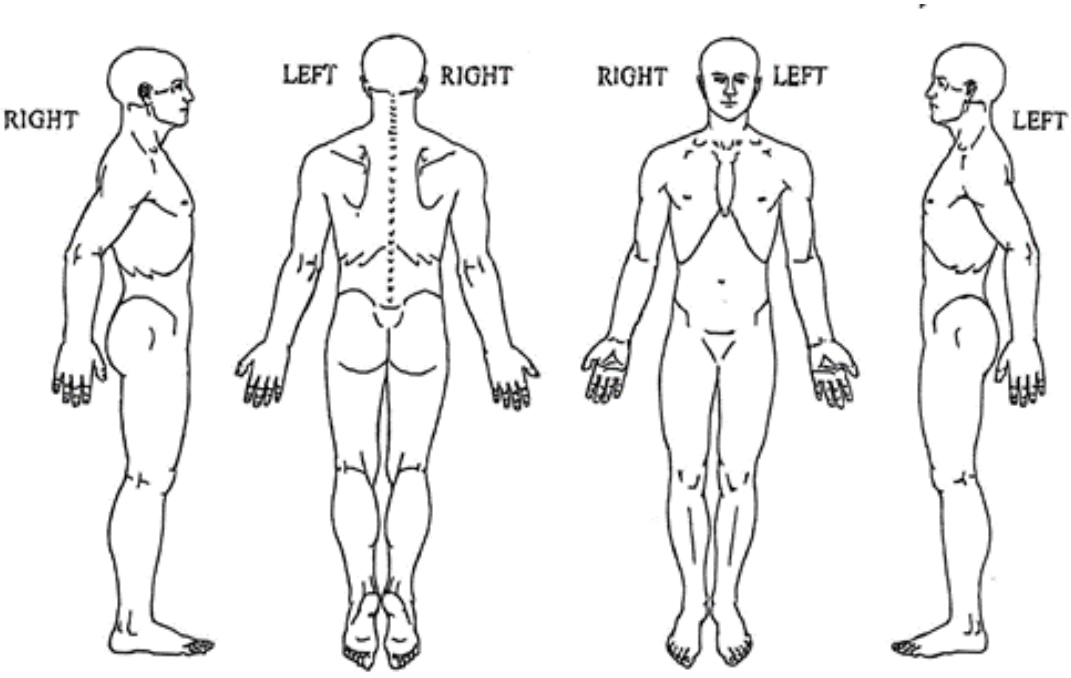
1) **WHEN** did this happen? _____
2) **HOW** did this happen? _____
3) Did this happen at work or in an auto accident? YES NO Circle One: Work Injury | Auto Accident
4) Primary Complaint/ Symptom: _____
5) All other Complaints/ Symptoms: _____
6) Are you having trouble sleeping? YES NO Is pain waking you at night? YES NO
7) What makes it feel better? _____
8) What makes it feel worse? _____
9) Does it: Move | Radiate | Stay Where? _____
10) How often do you experience the pain or discomfort since it most recently started? (Pick ONE)

☐ Constantly (always there) ☐ Daily (comes and goes) ☐ ___ Days a Week ☐ Weekly ☐ ___Days a Month

11) Pain Scale (1=no pain, 10=worst pain) Pick ONE: **1 2 3 4 5 6 7 8 9 10**
12) Describe how your pain or discomfort feels (Circle all that apply)

Dull | Achy | Cramping |Throbbing | Sharp | Tight | Burns | Numb | Tingling | Pins and Needles

13) Circle on the bodies everywhere you feel any discomfort or pain.



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- Functional Rating Index -

Please circle the number which most closely describes your primary complaint.

	0	1	2	3	4
1) Personal Care: (bathing, dressing, etc.)	No Pain; No restrictions	Mild pain; No restrictions	Moderate Pain; Need to go slowly	Moderate Pain; Need some assistance	Severe Pain; Need 100% assistance
2) Travel: (driving, etc.)	No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips
3) Work:	Can do usual work, plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work
4) Recreation Activities:	Can do all	Can do most	Can do some	Can do a few	Cannot do any
5) Lifting:	No pain with heavy lifting	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight
6) Walking:	No pain; Any distance	Increased pain after one mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with any walking
7) Standing:	No pain After several hours	Increased pain after several hours	Increased pain after 1 hr	Increased pain after ½ hr	Increased pain with any standing

Please check all <u>CURRENT</u> symptoms.

□ **Neck Pain/ Stiffness** □ **Mid Back Pain** □ **Lower Back Pain** □ **Muscle Spasms** □ **Joint Swelling/ Pain**	□ **Bladder/ UTI** □ **Menstrual Difficulties/Irregularities** □ **Constipation** □ **Indigestion** □ **Acid Reflux/ Belching** □ **Vomiting** □ **Diarrhea** □ **Hemorrhoids**	□ **Cold Hands** □ **Circulatory Problems** □ **Shortness of Breath** □ **Chest Pain/ Tightness**	□ **Fever** □ **Nervousness** □ **Irritability** □ **Fatigue** □ **Stress** □ **Tension** □ **Sleep Problems** □ **Hot/ Cold Sweats**
□ **Knee Pain** □ **Leg Cramps** □ **Leg Tingling/ Numbness** □ **Leg Weakness** □ **Toes Tingling/ Numbness**	□ **Shoulder Pain** □ **Arm Pain** □ **Arm Tingling/ Numbness** □**Fingers Tingling/ Numbness**	□ **Dizziness** □ **Loss of Balance** □ **Fainting** □ **Ringing in Ears** □ **Headaches: Frequency:_____** □ **Migraines: Frequency:_____** □ **Light Sensitivity** □ **Loss of Smell/ Taste**	□ **Allergies** □ **Asthma** □ **Hay Fever** □ **Hives** □ **Other** **_____**
□ **Recent Bowel/ Bladder Changes** □ **Difficulty Urinating**			

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Please check if you or any of your immediate family has HISTORY of:

□ **ADD/ ADHD** □ **Alcoholism** □ **Allergies** □ **Arthritis** *Type:*_____ □ **Birth Trauma** □ **Blood Pressure Low/High** □ **Broken Bones/ Fractures** □ **Cancer** *Type:*_____ □ **Cholesterol – High** □ **Chronic Fatigue** □ **Colitis** □ **Convulsions** □ **Depression**	□ **Diabetes** □ **Drug Addiction** □ **Eating Disorder** □ **Eye Condition** □ **Fibromyalgia** □ **Gallbladder Problems/ Removal** □ **Gastric/ Reflux/ Ulcer** □ **Glasses/ Contacts** □ **Heart Disease** □ **Hepatitis** □ **HIV/ AIDS** □ **Immune System – Weak**	□ **Irritable Bowel Syndrome** □ **Kidney Disease** □ **Liver Disease** □ **Lung Disease** □ **Lupus** □ **Mental Illness** □ **Multiple Sclerosis** □ **Muscular Dystrophy** □ **Neuritis/ Neuralgia** □ **Osteoporosis** □ **Rheumatoid Arthritis** □ **Scarlet Fever** □ **Scoliosis**	□ **Seizures** □ **Shingles** □ **Skin Disorder** □ **Sleep Disorder** □ **Stroke/ Hypertension** □ **Thyroid Disease** □ **Varicose Veins** □ **Venereal Disease** □ **Weight Gain/ Loss** □ **Other** _____ □ **Other** _____ □ **Other** _____ □ **Other** _____

Who Have You Seen:	**Have You Had:**
Who have you seen for your symptoms and when? Date Chiropractor: _____ _____ Medical Doctor: _____ _____ Physical Therapist: _____ _____ Other: _____ _____	□ **Blood Analysis** □**Blood Pressure Check** □ **Bone Density Testing** □ **Eye Exam** □ **MRI/ CT/ PET Scan** □ **Spinal X-Ray** □ **Surgeries (list below with date):** _____ _____ _____ _____ _____ _____