CCLC New Patient Paperwork

1. Please enter your information.

First Name: ____________ Middle Initials: ____________ Last Name: ____________ Date of Birth: ____________

Age ____________

Gender:
- Female
- Male

Marital Status:
- Single
- Married
- Domestic Partner
- Separated
- Divorced
- Widowed

Spouse's Name ____________ Number of children and ages ____________

Street Address: ____________ Apt./Unit #: ____________ City: ____________ State: ____________ Zip Code: ____________

Mobile Phone: ____________ Home Phone: ____________ Work Phone: ____________

Email: ____________

Preferred contact method:
- Mobile Phone
- Home Phone
- Work Phone
- Email

Occupation ____________

2. I am a...

- New Patient
- Current Patient
- Previous Patient Reactivation

3. How do you prefer appointment reminders?

- Text
- Email
- Phone Call

4. Emergency Contact

Contact Name ____________

Contact Phone ____________

Contact Relationship ____________

5. How did you hear about us?

- Family/Friend Referral
- Google
- Facebook/Instagram
- Radio
- Paper
- Healthcare Practicioner
- Other

6. Females Only

First day of my last menstrual cycle was...

Are you pregnant or nursing?

I hereby grant Complete Chiropractic Life Center permission to perform an x-ray evaluation, if needed. I understand x-rays are being performed to locate vertebral subluxation and not to diagnose or treat any other disease or condition.

Signature

Date

This health questionnaire is comprehensive. The more thoroughly you fill it out, the better we can serve you. Thank you!

7. Please list your 5 major health concerns in order of importance to you:

	Complaint	Since when?	Causes
1			
2			

8. Have you ever been involved in an accident? (Automobile, work, falls, sports, etc)

9. Chief Complaints

What is the ONE THING you are MOST needing help with?

Is this the first occurrence or have you experienced this before?

When was the first time EVER you recall experiencing this?

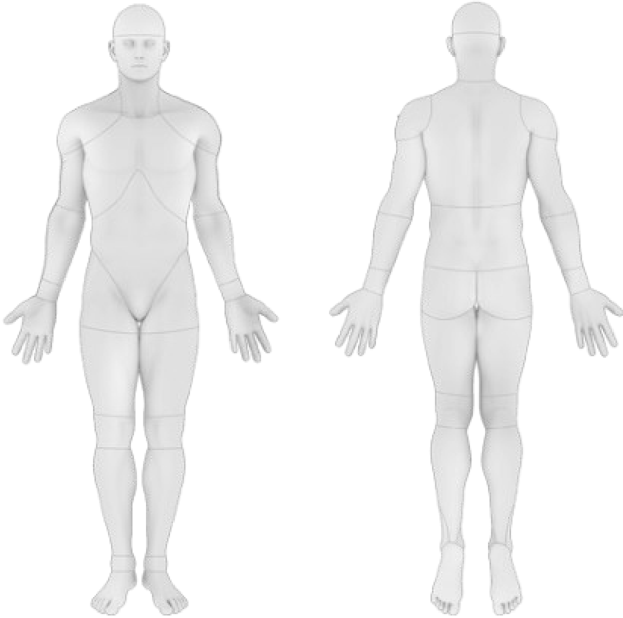
On a scale of 1-10, with 10 as WORST, how would you currently rate your condition

To feel like you could carry on normally, what would the condition have to get to on a scale of 1-10?

10. Is your complaint(s) the result of ANY type of accident?

- Yes
- No
- Other

11. Please mark on the area(s) of pain/discomfort/problem



12. Frequency: How often are you having pain or discomfort?

- ○ Less than once per week
- ○ Several times per week
- ○ Once a day
- ○ Several times per day
- ○ Most of the time

13. Duration: How long have you had the conditions about which you are consulting us?

- ○ Less than 6 months
- ○ 6 months to 2 years
- ○ 2 to 5 years
- ○ More than 5 years

14. Intensity: Please indicate the overall intensity of your symptoms:

- ○ Mild
- ○ Moderate
- ○ Severe
- ○ Very severe

15. Progression: How have your health problems progressed since they began?

- ○ Stable
- ○ Gradually improving
- ○ Rapidly improving
- ○ Fluctuating
- ○ Gradually worsening
- ○ Rapidly worsening

16. Are you currently under the care of a family physician or any other health professional? If yes, please indicate:

	Health professional's name	Health professional's contact	Condition	Treatment
1				
2				

17. Please list any prescribed medications you take:

	Name	Dosage	How long?
1			
2			

18. Please list all non-prescription medications you take:

	Name	Dosage	How long?
1			
2			

19. Please list any supplements you currently take or have taken in the recent past:

	Name of supplement	Dosage	How long?
1			
2			

20. Have you been diagnosed with any of the following conditions?

- ☐ Diabetes
- ☐ Cancer
- ☐ Irritable bowel
- ☐ Asthma
- ☐ Rheumatoid arthritis
- ☐ Other(s)
- ☐ Epilepsy
- ☐ Bleeding disorder
- ☐ Ulcerative colitis
- ☐ HIV / AIDS
- ☐ Kidney disease
- ☐ Heart condition
- ☐ Thyroid condition
- ☐ Liver disease
- ☐ Osteoporosis
- ☐ Cardiovascular disease

If "other(s)", please specify

____

21. What medical tests or investigations have you had recently? (Include reason for test and results)

____

____

____

____

22. Please list all surgeries you had:

	Surgery	When?
1		
2		
3		

23. Are you allergic to anything? (e.g.: foods, medications, pollens, chemicals, molds, animal hair, etc.)

____
____
____
____

24. Do you suffer from headaches? Migraines?

____
____
____
____

25. Describe symptoms of your headache or migraine (e.g.: frequency, duration, time of day what makes them better or worse – foods/coffee/time day/stress, describe the pain and location):

____
____
____
____

26. Head (mark all that apply)

- ☐ Temple Pain
- ☐ Eye Pain
- ☐ Dizziness
- ☐ Ear Pain
- ☐ Forehead Pain
- ☐ Entire Head Pain
- ☐ Fainting
- ☐ Ringing in Ears
- ☐ Top of head pain
- ☐ Base of skull pain
- ☐ Lighteaded
- ☐ N/A

27. Neck (Mark all that apply)

- ☐ Stiffness
- ☐ Pain with side-to-side movements
- ☐ Grinding with neck movements
- ☐ Diagnosed with disc degeneration
- ☐ History of neck fracture(s)
- ☐ Pain when turn head
- ☐ Muscle Spasms in the neck
- ☐ Diagnosed with Bone Spurs
- ☐ History of neck surgery
- ☐ Cortisone shot in neck
- ☐ General neck pain
- ☐ N/A

28. Shoulders (mark all that apply)

- ☐ Pain in the left shoulder
- ☐ Pain in the right shoulder
- ☐ Side shoulder pain
- ☐ Arthritis
- ☐ Can't place hand in back pocket
- ☐ Cortisone shot in shoulder
- ☐ Front shoulder pain
- ☐ Back shoulder pain
- ☐ Bursitis
- ☐ Can't raise arm past 90 deg
- ☐ Can't raise arm above head
- ☐ N/A

29. Arms/Hands (Mark all that apply)

- ☐ Pain in right upper arm
- ☐ Pain in left upper arm
- ☐ Pain in right forearm
- ☐ Pain in left forearm
- ☐ Pain in right wrist
- ☐ Pain in left wrist
- ☐ Hands cold
- ☐ Swollen joints in fingers
- ☐ Sore joints in fingers
- ☐ Arthritis
- ☐ Loss of grip strength
- ☐ Cortisone shot in hand/wrist
- ☐ Pain in fingers
- ☐ Pins & needles in right hand
- ☐ Pins & needles in left hand
- ☐ Pins & needles in right arm
- ☐ Pins & needles in left arm
- ☐ Fingers go to sleep
- ☐ N/A

30. Mid Back (mark all that apply)

- ☐ Mid-back pain
- ☐ Pain between shoulders
- ☐ Pain up/down back
- ☐ Pain across back
- ☐ Pain with breathing
- ☐ Cortisone shot in mid-back
- ☐ N/A

31. Lower Back (mark all that apply)

- ☐ Low Back Pain
- ☐ Standing hurts lower back
- ☐ Sitting hurts lower back
- ☐ Bending hurts lower back
- ☐ Walking hurts lower back
- ☐ Pain up/down lower back
- ☐ Pain across lower back
- ☐ Diagnosed disc problem
- ☐ Cortisone shot in lower back
- ☐ N/A

32. Hip (mark all that apply)

- ☐ Pain in buttocks
- ☐ Hip pain with standing
- ☐ Hip pain with sitting
- ☐ Pain on side of hip
- ☐ Pain in tailbone
- ☐ Bursitis in hip(s)
- ☐ Arthritis in hip(s)
- ☐ Cortisone shot in hip(s)
- ☐ Right Hip Pain
- ☐ Left Hip Pain
- ☐ Hips imbalanced
- ☐ N/A

33. Legs/Feet (mark all that apply)

- ☐ Pain down right leg
- ☐ Pain down left leg
- ☐ Leg cramps
- ☐ Pins & needles in right leg
- ☐ Pins & needles in left leg
- ☐ Numbness in right leg
- ☐ Numbness in left leg
- ☐ Numbness in right foot
- ☐ Numbness in left foot
- ☐ Numbness in toes
- ☐ Feet feel cold
- ☐ Cramps in right foot
- ☐ Cramps in left foot
- ☐ Swollen right ankle
- ☐ Swollen left ankle
- ☐ Swollen right foot
- ☐ Swollen left foot
- ☐ Pain in right knee
- ☐ Pain in left knee
- ☐ Pain in right ankle
- ☐ Pain in left ankle
- ☐ Pain right foot
- ☐ Pain in left foot
- ☐ Leg surgery
- ☐ Knee surgery
- ☐ Ankle surgery
- ☐ Foot surgery
- ☐ Diagnosed arthritis
- ☐ Cortisone shot in knees
- ☐ Cortisone shot in feet(s)
- ☐ Pain emanating from heel to toe
- ☐ Feet turn inward
- ☐ Feet roll inward
- ☐ Ankle weakness
- ☐ Calf Stiffness
- ☐ N/A
- ☐ Feet roll outward

34. On a scale of 1 to 10 indicate where your energy levels are currently:

Energy levels:
○ 1 (Little to No Energy) ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 (Lots of Energy)

35. Cardiovascular health. Do you suffer from any of the following conditions?

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ High colesterol
- ☐ Chest pain
- ☐ Heart palpitations
- ☐ Bruise easily
- ☐ Varicose veins
- ☐ Cold hands and feet
- ☐ Swollen feet or ankles
- ☐ Palpitations on exertion
- ☐ N/A

36. Cognitive Health

Do you ever feel as though you have memory lapses?
○ Yes ○ No

Select all that apply.
☐ Have trouble focusing? ☐ Have trouble sleeping? ☐ Have trouble clearing your mind?
☐ Problems coming up with the right word or name?
☐ Trouble remembering names when introduced to new people?
☐ Having greater difficulty performing tasks in social or work settings?
☐ Easily forget the material you just read? ☐ Increasingly common to lose or misplace valuable object(s)?
☐ Increasingly troublesome to plan or organize? ☐ Do you have forgetfulness of recent events?
☐ Difficulty performing complex tasks (such as planning dinner for guests, paying bills, or managing finances?)
☐ Do you have forgetfulness about one's own personal history? ☐ Do you become moody or withdrawn?
☐ Have you become unable to recall your address or telephone or the high school from which you graduated?
☐ Confused about where you are or what day it is, but still remember significant details about yourself and your family?
☐ Do you have a loss of awareness of recent experiences as well as of your surroundings?
☐ Do you need help dressing properly?
☐ Have you experienced major changes in sleep patterns, and/or trouble controlling your bladder or bowels?
☐ Have you experienced major personality and behavioral changes, wander, or become lost?

37. Does anyone in your family suffer with the same condition(s)?

☐ No ☐ Grandmother ☐ Grandfather
☐ Mother ☐ Father ☐ Sister
☐ Brother ☐ Son ☐ Daughter

38. Weight

Are you happy with your weight? Do you feel you need to lose or gain weight?

___

Has your doctor recommended that you lose weight?

___

What is your current weight and height?

___

Do you have a history of dieting? Please describe:

___

Have you ever suffered from an eating disorder? Please describe:

___

For athletes, do you need to lose body fat or put on muscle mass?

___

39. Pillars of Health

Nutrition is a critical part of health and development. How would you describe your typical diet?

___

List the three worst foods you eat during the average week.

____

List the three healthiest foods you eat during the average week.

____

Do you exercise regularly?

____

How would you best describe your activity level?

____

What activity/activities do you perform most commonly each day? (walking/lifting/climbing/standing/etc)

____

Rest is important. How would you describe your time of rest?

____

Sleep is a necessary physiological process. How would you describe your sleep?

____

Mental Attitude: How would you describe your mental attitude? (Ex: positive? negative?)

____

40. Do you drink alcohol? If yes, please specify:

How much alcohol do you consume per week? ______________

Type of alcohol: ______________

Do you drink in excess? ______________

Did you ever drink alcohol in excess? ______________

If applicable, when did you stop? ______________

41. Smoking Answer when applicable:

Do you smoke?
☐ Yes ☐ No

How much per day? ______________

For how long? ______________

When did you stop? ______________

Do you work or live closely with a smoker? ______________

How long have you been living closely with a smoker? ______________

42. Family Health History. Please list any known family diseases or illnesses such as diabetes, cancer, heart disease or mental illness (depression, bi polar, schizophrenia, etc.):

____

____

____

____