

NEW PATIENT CHECKLIST PAGE 2

Please list your major ailments in order of severity (from most debilitating to least debilitating):

1.	4.
2.	5.
3.	6.

Primary Ailment - _____

When did you first notice this condition:
Did it begin: <input type="checkbox"/> Immediate or <input type="checkbox"/> Gradually? Briefly describe:
What is the exact location of your symptoms:
Do your symptoms Spread? <input type="checkbox"/> No <input type="checkbox"/> Yes. Where?
How often do you experience these symptoms? <input type="checkbox"/> Constant (100% of day) <input type="checkbox"/> Frequent (75% of day) <input type="checkbox"/> Often (50%) <input type="checkbox"/> Seldom (25%) <input type="checkbox"/> Rarely (less than 25%)
Is this condition progressively: <input type="checkbox"/> Worsening <input type="checkbox"/> Improving or <input type="checkbox"/> Unchanged
What is the intensity of your symptoms? <input type="checkbox"/> Severe <input type="checkbox"/> Moderate <input type="checkbox"/> Mild
Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating pain): <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10
Is your pain <input type="checkbox"/> Deep or <input type="checkbox"/> Superficial
Please indicate the character of your pain: <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Burning <input type="checkbox"/> Aching <input type="checkbox"/> Knife-like Throbbing
Are you experiencing any of the following associated symptoms? <input type="checkbox"/> Pins/Needles <input type="checkbox"/> Tingling <input type="checkbox"/> Numbness <input type="checkbox"/> Twitching If Yes, Please describe:
Please indicate what activities provoke (P) or Aggravate (A) your condition: __ Sitting for __ min., __ Standing, __ Walking, __ Lying, __ Pushing, __ Pulling, __ Lifting __ lbs., __ Gripping Hot/Cold, __ Coughing/sneezing, __ Bowel Movements, __ Mental Activities, __ Bright lights, __ Other _____, __ Other _____, __ Other _____
Please indicate what helps to alleviate the pain. <input type="checkbox"/> Lying <input type="checkbox"/> Sitting <input type="checkbox"/> Walking <input type="checkbox"/> Standing <input type="checkbox"/> Rest <input type="checkbox"/> Heat/Cold <input type="checkbox"/> Medications _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____

Please list what doctors you have seen for this condition. (Please include diagnoses, treatment received, and any changes in your condition.)

Please include any other relevant history in regards to this ailment.

NEW PATIENT CHECKLIST PAGE 3

Additional Ailment - _____

When did you first notice this condition:
Did it begin: <input type="checkbox"/> Immediate or <input type="checkbox"/> Gradually? Briefly describe:
What is the exact location of your symptoms:
Do your symptoms Spread? <input type="checkbox"/> No <input type="checkbox"/> Yes. Where?
How often do you experience these symptoms? <input type="checkbox"/> Constant (100% of day) <input type="checkbox"/> Frequent (75% of day) <input type="checkbox"/> Often (50%) <input type="checkbox"/> Seldom (25%) <input type="checkbox"/> Rarely (less than 25%)
Is this condition progressively: <input type="checkbox"/> Worsening <input type="checkbox"/> Improving or <input type="checkbox"/> Unchanged
What is the intensity of your symptoms? <input type="checkbox"/> Severe <input type="checkbox"/> Moderate <input type="checkbox"/> Mild
Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating pain): <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10
Is your pain <input type="checkbox"/> Deep or <input type="checkbox"/> Superficial
Please indicate the character of your pain: <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Burning <input type="checkbox"/> Aching <input type="checkbox"/> Knife-like Throbbing
Are you experiencing any of the following associated symptoms? <input type="checkbox"/> Pins/Needles <input type="checkbox"/> Tingling <input type="checkbox"/> Numbness <input type="checkbox"/> Twitching If Yes, Please describe:
Please indicate what activities provoke (P) or Aggravate (A) your condition: __ Sitting for __ min., __ Standing, __ Walking, __ Lying, __ Pushing, __ Pulling, __ Lifting __ lbs., __ Gripping Hot/Cold, __ Coughing/sneezing, __ Bowel Movements, __ Mental Activities, __ Bright lights, __ Other _____, __ Other _____, __ Other _____
Please indicate what helps to alleviate the pain. <input type="checkbox"/> Lying <input type="checkbox"/> Sitting <input type="checkbox"/> Walking <input type="checkbox"/> Standing <input type="checkbox"/> Rest <input type="checkbox"/> Heat/Cold <input type="checkbox"/> Medications _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____

Please list what doctors you have seen for this condition. (Please include diagnoses, treatment received, and any changes in your condition.

Please include any other relevant history in regards to this ailment.

IF YOU HAVE MORE THAN TWO AILMENTS, PLEASE ASK THE RECEPTIONIST FOR ADDITIONAL "AILMENT" FORMS.

NEW PATIENT CHECKLIST PAGE 4

Past Medical History

Please include any of your previous conditions.

If possible, include: dates, diagnosis, treatment received and any residuals you still suffer from.

General Health History: Have YOU had any of the following?

Injuries, Accidents, Falls or Traumas: <input type="checkbox"/> No <input type="checkbox"/> Yes Explain:
Illnesses/Hospitalizations: <input type="checkbox"/> No <input type="checkbox"/> Yes Explain:
Surgeries: <input type="checkbox"/> No <input type="checkbox"/> Yes Explain:

Motor Vehicle Accidents: <input type="checkbox"/> No <input type="checkbox"/> Yes Explain:
Work Injuries: <input type="checkbox"/> No <input type="checkbox"/> Yes Explain:

Females Only - Menopausal Symptoms: <input type="checkbox"/> None <input type="checkbox"/> Yes Explain:

Habits

Cigarettes/Cigars	<input type="checkbox"/> None <input type="checkbox"/> Yes How much per week?
Alcohol	<input type="checkbox"/> None <input type="checkbox"/> Yes How many drinks per week? What type of Alcohol?
Coffee	<input type="checkbox"/> None <input type="checkbox"/> Yes How many cups per week?
Exercise	<input type="checkbox"/> None <input type="checkbox"/> Yes Hours/Days per week? Types?
Water	<input type="checkbox"/> None <input type="checkbox"/> Yes Glasses per day?
Soft Drinks	<input type="checkbox"/> None <input type="checkbox"/> Yes Amount per week? Types?
Sleep	<input type="checkbox"/> None <input type="checkbox"/> Yes Average per night? Do you have difficulty falling asleep or staying asleep? Hours desired per night?
Eating	Meals per day? What types of food do you eat? Do you consider your diet healthy? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:

Have any of your FAMILY MEMBERS ever suffered from any of the following conditions?

<input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Neurological Disorders _____ <input type="checkbox"/> Autoimmune Disorders _____ <input type="checkbox"/> Cancer _____ <input type="checkbox"/> Other _____

NEW PATIENT CHECKLIST PAGE 5

Personal Health History

Medications: Please list your current medications, how long you have been taking them and for what they are taken.
Vitamins and Minerals: Please list your current supplements.

Check the left box for any condition YOU had in the PAST, and the right box for any condition YOU have CURRENTLY.

GENERAL HEALTH HISTORY

P	C	P	C	P	C	P	C
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<u>NERVOUS SYSTEM</u>		<u>EYES/EARS/NOSE/THROAT</u>		<u>GASTROINTESTINAL</u>		<u>MUSCULOSKELETAL</u>	
P	C	P	C	P	C	P	C
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<u>CARDIOVASCULAR</u>		<u>REPRODUCTIVE</u>		<u>GENITOURINARY</u>	
P	C	P	C	P	C
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How many times per day do you urinate?	How often do you have a bowel movement?
Do you experience any <input type="checkbox"/> urgency, <input type="checkbox"/> dribbling, or <input type="checkbox"/> incontinence?	Do your stools <input type="checkbox"/> Float or <input type="checkbox"/> Sink?
Is this urination pattern consistent? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are your bowel movements consistent? <input type="checkbox"/> Yes <input type="checkbox"/> No

CONFIDENTIALITY

In the event this office needs to contact you:

May we leave a message for you with someone at your home phone number? Yes No

May we leave a message for you on your home answering machine? Yes No

May we leave a message for you with someone at your work phone number? Yes No

May we fax information that you request? Yes No

Agreement for Payment of Services (Please initial all that apply)

_____ I understand that Allen Chiropractic Neurology is not familiar with my Blue Cross/Blue Shield or Health Select health insurance policy, nor can they determine whether my insurance will pay for all or part of the services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ I acknowledge and agree that I will be personally responsible for all the payments for Allen Chiropractic Neurology services, whether or not my insurance pays for all or part of the services.

_____ I acknowledge that I have no other insurance coverage.

Patient Signature

Date