Patient Name: ______________________________ **Date:** ____________________

New Patient Information *(Page 1)*:

Thank you for choosing The Conde Center for Chiropractic Neurology. In our clinic, we carefully examine all of the systems in your body so that we may gather all information necessary in order to best address your healthcare and wellness. Please bear with us and all the paperwork we present to you. Please do not assume that any question is irrelevant or unimportant to your case, everything we ask here is highly relevant and extremely important! We need you to carefully and honestly answer every question so that we may piece together the best approach to managing your case. Please feel free to ask any questions. Thank you!

Check as many that apply to you about your reason for visiting us today:

Wellness care:	If yes, please indicate which of the following you are interested in:	Weight Loss	Hormone testing
		Genomic testing	Spinal & joint health
	Nutritional counseling	Food allergy testing	Neurological assessment
	Lifestyle management	Neurotransmitter testing	Other?
Motor vehicle accident? When did it occur?		**Recent Fall?** When did it occur?	
Another type of accident, trauma, or injury:	If yes, please answer the following:	Less than 3 days old	Between 3 days & 8 wks
		Between 8 wks & 4 months	More than 4 months
	Please explain what the incident was; was it at work, home, or somewhere else?		
Neurological problem or disease:	If yes, please explain & include any prior diagnoses:		
Diagnostics:	If yes, please explain what you think you are being treated and evaluated for:		

HxA-MVA
HxA-Fa
HxA-FN

Where you referred to us by another health care provider? No. Yes. If yes, who? ______________________________

Are you currently taking any medications (prescribed or over the counter), if so please list them and include dosage? *(if more than 12 meds, please tell us & we will provide you with more paper!)*

1. ____________. 5. ____________. 9. ____________.
2. ____________. 6. ____________. 10. ____________.
3. ____________. 7. ____________. 11. ____________.
4. ____________. 8. ____________. 12. ____________.

Are you currently taking any herbs or nutritional supplements, if so please list them? *(if more than 12, please tell us!)*

1. ____________. 5. ____________. 9. ____________.
2. ____________. 6. ____________. 10. ____________.
3. ____________. 7. ____________. 11. ____________.
4. ____________. 8. ____________. 12. ____________.

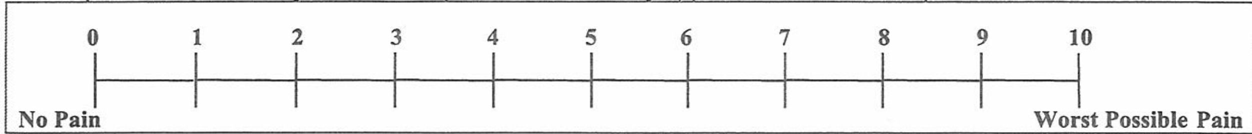
Do you have any known allergies, if so please list them? *(if more than 6, please tell us!)*

1. ____________. 2. ____________. 3. ____________.

If you have a Primary Complaint, please answer the following:

What is your primary complaint?____

Is there pain associated with your chief complaint? No. Yes. If yes, please mark where that pain is on a scale of 1-10?



Have you seen anyone else for this condition? No. Yes. If yes, who? ________________________________

Have you lost work days for this condition? No. Yes. If yes, how much?________________________________

Have you tried any self-treatments for this condition?________________________________

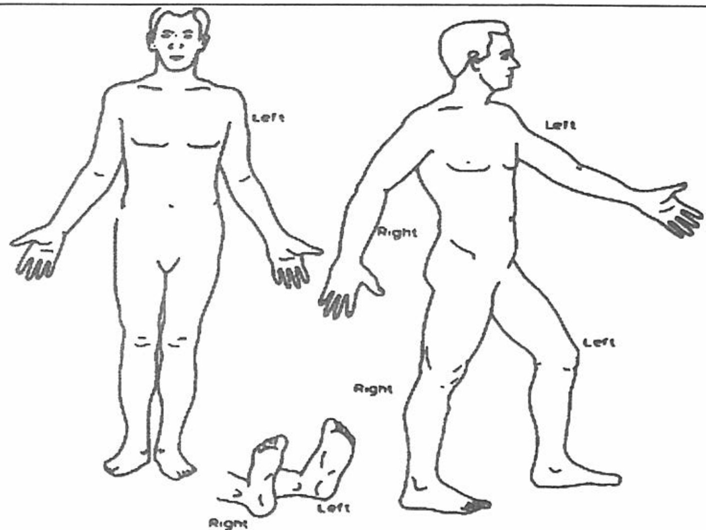
____

Have you ever been treated for a similar problem, if so describe?________________________________

Do you have any other complaints or concerns?________________________________

What do ***you*** think is causing your present health problem(s)?

On the diagram to the right, please mark the following symptoms, if you are experiencing them:
- "//" for stabbing pain,
- "**B**" for burning pain,
- "**D**" for dull pain,
- "**A**" for aching pain,
- "**N**" or in areas where you have numbness
- "**T**" in areas where you have tingling,
- "**St**" in areas where you feel stiffness,
- "**Sw**" in areas where you've had swelling,
- "**C**" in areas where you have cramps,



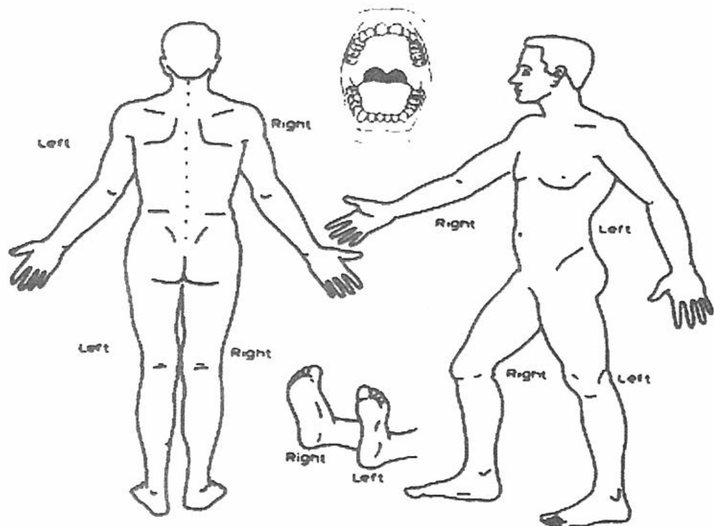
Below indicate any ***other*** symptoms you think may be important.

____

____

____

____



What are your **5 greatest concerns** about your present state of health?

1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________
5. ____________________________

Doctor's Notes:____

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Doctor's Initials:____________

Please answer the following questions as completely as possible:

Please list all operations or surgeries you may have had with dates:

Please list any hospitalizations you may have had with dates:

Please list any major illness you have had with dates:

Have you had any recent infections, colds, or flu? No. Yes:

Please list any and ***all*** traumas or injuries you've ever had, with dates, from the simple to the serious:

Have you ever been diagnosed with a tumor, cancer, neoplasia, or dysplasia? No. Yes:

Have you ever been diagnosed with diabetes? No. Yes:

Have you ever been diagnosed with a cardiac (heart) condition, a blood vessel condition (like arteriosclerosis, atherosclerosis, or vasculitis), or hypertension (high blood pressure)? No. Yes:

Have you ever had a stroke or heart attack? No. Yes:

Does anyone in your biological family (parent, grandparent, sibling, or child) have a history of heart disease, stroke, cancer, or diabetes? No. Yes, explain:

Does anyone in your biological family have a history of psychiatric diseases like depression, anxiety, schizophrenia, etc? No. Yes, explain:

Does anyone in your biological family have a history of neuropathies (nerve diseases) or myopathies (muscle diseases)? No. Yes, explain:

Does anyone in your biological family have a history of cancer? No. Yes, explain:

Does anyone in your biological family have a history of back or neck pain? No. Yes, explain:

Does anyone in your biological family have a history of any other known conditions? No. Yes, explain:

Please indicate your familial status? Single. Married. Divorced. Widowed.

How many children do you have? None. 1. 2. 3. 4. Other:________.

What do you do for a living?________. How many hours a week?

Do you have a second job?________. How many hours a week?

Describe your work environment:

How long have you been at this job?________What other jobs have you had in the past?

Describe your home life:

What is your highest level of education?________. What are your hobbies?

Doctor's Notes:

Doctor's Initials:

Do you exercise? No. Yes, then what type and how often:____________________

Do you use any tobacco products? No. Yes, then what kind, how often, & how long:____________________

Have you used tobacco products in the past? No. Yes, then what, how long, & when did you quit?____________________

Do you drink alcoholic beverages? No. Yes, then what kind and how many a week:____________________

Have you had alcohol problems in the past? No. Yes, then how long ago & for how long:____________________

Do you drink caffeinated beverages? No. Yes, then what kind and how many a day:____________________

Do you drink sodas? No. Yes, then how many a day:____________________

Do you use recreational drugs? No. Yes, then how long ago & for how long::____________________

Have you used recreational drugs in the past? No. Yes, then what type, when, & for how long:____________________

Do you have any special dietary restrictions? No. Yes, then what type:____________________

Are you sexually active? No. Yes. If yes have you ever been diagnosed with an STD or VD:____________________

When did you last see a chiropractor?____________. What were those visits for & how were the outcomes?____________________

____

Why have you changed chiropractors?____________________

Review of Systems & Medical History:

1. Are you currently experiencing any of the following symptoms, now or recently?
   - Chest pain
   - Jaw pain
   - Left arm pain
   - Shortness of breath
   - Excessive sweating without exertion
   - Pale skin or pallor
   - Blackouts
   - Swelling in your left arm
   - Lightheadedness
2. Please check off any of the below symptoms that you are be experiencing, now or recently?
   - Nausea
   - Vomiting
   - Difficulty with speaking
   - Dizziness or vertigo
   - Difficulty with swallowing
   - Disequilibrium or feeling unsteady
   - Double vision
   - Feeling like your are going to fall
   - Abnormal eye movements
   - Numbness
   - Abnormal sweating
   - Severe headache
3. Have you noticed any of the following?____________________
   - Change in appetite
   - Unexplained weight loss
   - Unexplained weight gain
   - Recent fever
   - Recent fatigue

R/F

Please mark any of the below conditions that apply to you, past or present.

Condition	Past	Present	Condition	Past	Present	Condition	Past	Present	Condition	Past	Present
☐ Swollen or painful joints			☐ Foot or ankle pain			☐ Trouble with prolonged sitting or standing			☐ Herniated disc		
☐ Neck pain or stiffness			☐ Leg pain			☐ Trouble with walking			☐ Lumbago or lumbalgia		
☐ Upper back pain or stiffness			☐ Knee pain			☐ Trouble with bending, twisting, or lifting			☐ Scoliosis or other spinal curvature		
☐ Mid back pain or stiffness			☐ Shoulder pain			☐ Osteoporosis			☐ Difficulty walking		
☐ Low back pain or stiffness			☐ Elbow pain			☐ Dislocated bones			☐ Osteoarthritis or DJD		
☐ Hip or pelvis pain			☐ Arm pain			☐ Fractured bones			☐ Rheumatoid arthritis		
☐ Auto accidents			☐ Hand or wrist pain			☐ Bone infection (osteomyelitis)			☐ Other arthritis		
			☐ Jaw pain or click (TMJ)			☐ Machine accident			☐ Gout		
			☐ Chronic headaches						☐ Ankylosing spondylitis		
			☐ Sprain or strain						☐ Accidental fall		
			☐ Sports injuries								

HxA-Pn

HxA-mva
HxA-Fa

Doctor's Notes:____________________

Doctor's Initials:____________

Condition	Past	Present
☐ Migraines		
☐ Cluster headaches		
☐ Costen's syndrome		
☐ Balance problems		
☐ Mental or emotional disorder		
☐ Convulsions or epilepsy		
☐ Difficulty speaking		
☐ Difficulty swallowing		
☐ Losing time or blacking out		
☐ Changes in skin sensation		
☐ Muscle problems		
☐ Learning disability		
☐ Conduct disorder		
☐ Glaucoma		
☐ Dizziness		
☐ Motion sickness		
☐ Ear infections		
☐ Tinnitus		
☐ Sore throat		
☐ Pain in legs with movement or activity		
☐ Heart palpations (hearing racing heart)		
☐ Swelling in legs or feet		
☐ Congestive heart failure		
☐ Difficulty breathing		
☐ Chronic/frequent cough		
☐ COPD		
☐ Coughing up blood		
☐ Difficulty losing weight		
☐ Colon problems		
☐ Gall bladder trouble		
☐ Liver disease		
☐ Stomach/duodenal ulcer		
☐ Abdominal pain		
☐ Indigestion		
☐ Cirrhosis		
☐ Bloating		
☐ Craving sweets		
☐ Craving excessive salts		
☐ Pituitary disorder		
☐ Cold all the time		
☐ Dry skin		
☐ Change in hat size		
☐ Unexplained skin rash		
☐ Change in skin mole		
☐ Seborrhea		
☐ Acne		

Condition	Past	Present
☐ Trigeminal neuralgia or Tic Doloreaux		
☐ Hypertension headache		
☐ Seizures		
☐ Neurological disease		
☐ Trouble concentrating		
☐ Difficulty swallowing		
☐ Trouble understanding others		
☐ Stroke or CVA		
☐ Paralysis		
☐ Muscle weakness		
☐ Twitching muscles		
☐ Lost muscle tone		
☐ ADD or ADHD		
☐ Behavioral disorder		
☐ Macular degeneration		
☐ Vertigo		
☐ Unexplained giddiness		
☐ Ringing in ears		
☐ Sinus problems		
☐ Mouth sores		
☐ Heart attack (myocardial infarct)		
☐ Irregular heart beats		
☐ Experience passing out		
☐ Skipped heart beats		
☐ Congenital heart disease		
☐ Shortness of breath with activity		
☐ Short of breath at rest		
☐ Painful breathing		
☐ Hemorrhoids		
☐ Difficulty with control of bowel movements		
☐ Nausea &/or vomiting		
☐ Digestive problems		
☐ Constipation		
☐ Diarrhea		
☐ Polyps		
☐ Diverticulitis		
☐ Hormonal issues		
☐ Thyroid disorder		
☐ Adrenal disorder		
☐ Hot all the time		
☐ Trouble with sleep		
☐ Change in glove size		
☐ Itching		
☐ Change in nails		
☐ Eczema		
☐ Dermatitis		

Condition	Past	Present
☐ Tension headaches		
☐ Pain in your face		
☐ Temporal arteritis		
☐ Trouble sleeping		
☐ Difficulty with focus		
☐ Loss of memory		
☐ Fainting spells		
☐ Tire easily		
☐ Mini-stroke or TIA		
☐ Blurred vision		
☐ Double vision		
☐ Muscle cramping		
☐ Tremors (shaking)		
☐ Abnormal movements		
☐ Dyslexia		
☐ Asperger's syndrome		
☐ Cataracts		
☐ Unsteadiness		
☐ Difficult with balance		
☐ Earaches		
☐ Nose bleeds		
☐ Bleeding gums		
☐ Arrhythmia		
☐ Heart murmur		
☐ Atherosclerosis / arteriosclerosis		
☐ Dizzy or light-headed with exercise		
☐ Wheezing		
☐ Asthma		
☐ Coughing up mucus		
☐ Pneumothorax		
☐ Difficulty swallowing		
☐ Gall bladder stones		
☐ Intestinal issues		
☐ Heartburn		
☐ Gastric ulcers		
☐ Excessive belching		
☐ Digestive issues		
☐ Celiac Disease (Sprue)		
☐ Irritable bowel syndrm.		
☐ Night sweats		
☐ Decreased energy		
☐ Frequent urination		
☐ Hair loss		
☐ Increased sex drive		
☐ Under a lot of stress		
☐ Change in hair pattern		
☐ Bruise easy		
☐ Psoriasis		
☐ Skin cancer		

Condition	Past	Present
☐ Sinus headaches		
☐ Cervicogenic headaches		
☐ Other type of headache		
☐ Recent incoordination		
☐ Head seems heavy/tired		
☐ Head or arms feel tired		
☐ Loss of consciousness		
☐ Concussions		
☐ Head injury		
☐ Persistent headache		
☐ Spontaneous movement		
☐ Weak muscles of face		
☐ Numbness or tingling		
☐ Excessive sweating		
☐ Autism (PDD or ASD)		
☐ Bedwetting		
☐ Retinopathy		
☐ Pain with coughing or sneezing		
☐ Hearing loss		
☐ Difficulty swallowing		
☐ Hoarseness		
☐ High cholesterol		
☐ High blood pressure (hypertension)		
☐ Scarlet fever		
☐ Rheumatic fever		
☐ Other heart disease		
☐ Emphysema		
☐ Bronchitis		
☐ Snoring		
☐ Other lung problems		
☐ Hepatitis		
☐ More than 3 bowel movements a day		
☐ Less than 1 bowel movement a day		
☐ Excessive gas		
☐ Blood in stool		
☐ Ulcerative colitis		
☐ Crohn's disease		
☐ Diabetes		
☐ Hyperthyroidism		
☐ Hypothyroidism		
☐ Excessive thirst		
☐ Decreased sex drive		
☐ Change in skin color		
☐ Shingles		
☐ Herpes		
☐ Warts		
☐ Other skin disorder		

HxA-fn

HxA-GI

HxA-En

Doctor's Notes:______________________________

Doctor's Initials:______________