



COASTAL WELLNESS
FAMILY CHIROPRACTIC

New Patient Information

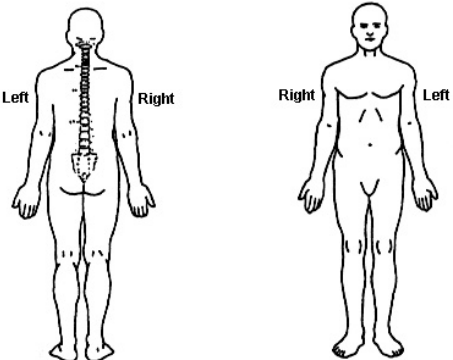
Personal Information	Name: _____ Spouse: _____
	Address: _____ City: _____ State: _____ Zip: _____
	Email: _____ Home Phone: _____ (Your email will NOT be shared with 3 rd parties. It is for general office announcements and promotions.)
	Age: _____ Birth date _____ Sex: M F Marital Status: M S W D
	Number of Children and Ages: _____
	Employer: _____ Work Phone: _____
	Type of Work Performed: _____
	In Case of Emergency, Notify: _____ Phone: _____
Family Physician: _____	
Who Should We Thank For Telling You About Our Office? _____	
Current Health Concern	Primary Reason For Today's Visit: _____
	Check The Severity Of Your Complaint: (Mild) _____ (Severe)
	Date Symptoms First Appeared: _____ Experienced Previously: Yes No
	Is This Condition: _____ Job Related _____ Auto Accident _____ Fall or Injury _____ Other
List Any Other Practitioners Seen For This Injury/Condition: _____	
Past Health History	Previous Surgeries: _____ Eyes/Ears/Nose/Throat _____ Head/Neck _____ Back/Spine _____ Chest/Heart/Lungs _____ Abdominal _____ Other: _____
	Previous Fractures Or Broken Bones? Yes No Explain: _____
	Previous Falls Or Accidents? Yes No Explain: _____
	Previous Hospitalizations? Yes No Explain: _____
	Previous Car Accidents? Yes No Explain: _____
	Previous Chiropractic Care? Yes No Explain: _____
	Do You Workout or Exercise? Yes No Explain: _____
	Do You Take Any Medications? Yes No List: _____
	Do You Take Any Vitamins/Herbs? Yes No List: _____
	Have You Ever Had X-Rays Taken? Yes No Where: _____
	Date of Last Physical Exam: _____
Any Chance That You Are Pregnant? Yes No	

New Patient Information Continued

Family History	Family Member Past & Present Health Conditions (Example: Heart Disease, Diabetes, Cancer, etc)

Check Any Of The Following That Apply To You	Health Issues: ____ Polio ____ Arthritis ____ Diabetes ____ Sleeplessness ____ Cancer ____ AIDS or ARC ____ Heart ____ Chronic Fatigue ____ Frequent Illness ____ Allergies ____ Genetic Disorders ____ High Stress ____ Poor Diet ____ Epilepsy ____ Over Weight ____ Under Weight ____ Other: _____				
	Habits:	None	Light	Moderate	Heavy
	Alcohol	_____	_____	_____	_____
	Tobacco	_____	_____	_____	_____
	Drugs	_____	_____	_____	_____
	Pain Relievers	_____	_____	_____	_____
	Caffeine	_____	_____	_____	_____
	Sleep	_____	_____	_____	_____
	Artificial Sweeteners	_____	_____	_____	_____
	Exercise	_____	_____	_____	_____
	Water	_____	_____	_____	_____

Check Any Problems You Have Ever Suffered From	<input type="checkbox"/> Low Back Pain <input type="checkbox"/> Middle Back Pain <input type="checkbox"/> Neck Pain <input type="checkbox"/> Shoulder/Arm Pain <input type="checkbox"/> Joint Pain/Stiffness <input type="checkbox"/> Hip/Leg Pain <input type="checkbox"/> Chest <input type="checkbox"/> Lungs/Breathing <input type="checkbox"/> Blood Pressure <input type="checkbox"/> Heart Rate <input type="checkbox"/> Chest Pain <input type="checkbox"/> Sinus Pain <input type="checkbox"/> Eyes/Vision <input type="checkbox"/> Dental/TMJ <input type="checkbox"/> Throat/Voice <input type="checkbox"/> Ears/Hearing <input type="checkbox"/> Sinus Infections <input type="checkbox"/> Headaches <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Dizziness <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Depression <input type="checkbox"/> Fainting <input type="checkbox"/> Cold Hands/Feet <input type="checkbox"/> Seizures <input type="checkbox"/> Stress Reactions <input type="checkbox"/> Shaking/Tremors <input type="checkbox"/> Poor Appetite <input type="checkbox"/> Nausea <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Weight Loss/Gain <input type="checkbox"/> Heartburn <input type="checkbox"/> Change in Stools <input type="checkbox"/> Genital <input type="checkbox"/> Pain With Urination <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Infrequent Urination <input type="checkbox"/> Weak Stream <input type="checkbox"/> Bladder Control <input type="checkbox"/> Menstrual <input type="checkbox"/> Lumps (Breast/Genital)			
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Please Mark Areas of Concern		All Information on This Form is Confidential I certify that I have completed this form to the best of my ability, and that the statements I have provided are true.
	Patient/Guardian	Date