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New Patient Application

At Keep Moving Chiropractic, we are committed to serve our patients in a professional clinical environment and to empower patients to actively participate in their healthcare. If you are accepted as a patient at Keep Moving Chiropractic we will give our expert recommendation to help achieve the most amount of improvement in the least amount of time.

SECTION 1:
Personal Data

Patient's Name: First_____MI_____Last_____

Prefers to be called_____Birthdate____/____/____M ☐ F ☐

Parent or Guardian's Name if Patient is a Minor _____

Home Address _____

City_____State_____Zip_____

Home Ph# (___)_____Work Ph# (___)_____Cell Ph# (___)_____

Email Address_____Contact Preference: Home Ph# ☐ Work Ph# ☐ Cell Ph# ☐ Email ☐

Occupation_____Current Employer_____Contact Ph#(___)_____

Work Address_____City_____State_____Zip_____

Are you currently pregnant? ☐Yes ☐No ☐Maybe Have you ever been pregnant?☐Yes ☐No

Number of Children_____Ages_____

A copy of your insurance card[s] will be made, in addition, please complete the information requested below:

Insurance Information Are you the policy holder? ☐Yes ☐No If No, who is? Spouse☐ Parent☐ Employer☐

Policy Holder's First Name _____MI_____Last_____DOB:_____

Policy Holder's Social Security #:_____Policy Holder's Employer:_____

Do you have secondary insurance? Yes ☐ No☐ If yes, please complete the following:Same as above ☐

Policy Holder's First Name _____MI_____Last_____DOB:_____

Policy Holder's Social Security #:_____Policy Holder's Employer:_____

Referred By_____

Emergency Contact Person_____Phone# (___)_____

SECTION 2

Reason for Beginning Care

I am here for a specific condition ☐Yes ☐ No If NO, please go directly to SECTION 3

Primary Complaint	Secondary Complaint	Tertiary Complaint
Brief Description of Complaint	**Brief Description**	**Brief Description**
Pain Scale BEST WORST 0 1 2 3 4 5 6 7 8 9 10	**Pain Scale** BEST WORST 0 1 2 3 4 5 6 7 8 9 10	**Pain Scale** BEST WORST 0 1 2 3 4 5 6 7 8 9 10
Is it constant? ☐ Yes ☐ No Comes & Goes? ☐ Yes ☐ No **Please check ALL that describe your current symptoms?** ☐ Sharp ☐ Stabbing ☐ Tingling ☐ Pins/Needles ☐ Dull ☐Aching ☐ Numbness ☐Tightness ☐Pinching ☐ Other	Is it constant? ☐ Yes ☐ No Comes & Goes? ☐ Yes ☐ No **Please check ALL that describe your current symptoms?** ☐ Sharp ☐ Stabbing ☐ Tingling ☐ Pins/Needles ☐ Dull ☐Aching ☐ Numbness ☐Tightness ☐Pinching ☐ Other	Is it constant? ☐ Yes ☐ No Comes & Goes? ☐ Yes ☐ No **Please check ALL that describe your current symptoms?** ☐ Sharp ☐ Stabbing ☐ Tingling ☐ Pins/Needles ☐ Dull ☐Aching ☐ Numbness ☐Tightness ☐Pinching ☐ Other
Do any of the following worsen your condition? ☐Driving ☐Walking ☐Sitting ☐Bending ☐Standing ☐Breathing ☐Coughing ☐Sneezing ☐Sleeping ☐Working ☐Exercising ☐Other ☐Bowel Movement	**Do any of the following worsen your condition?** ☐Driving ☐Walking ☐Sitting ☐Bending ☐Standing ☐Breathing ☐Coughing ☐Sneezing ☐Sleeping ☐Working ☐Exercising ☐Other ☐Bowel Movement	**Do any of the following worsen your condition?** ☐Driving ☐Walking ☐Sitting ☐Bending ☐Standing ☐Breathing ☐Coughing ☐Sneezing ☐Sleeping ☐Working ☐Exercising ☐Other ☐Bowel Movement
Do any of the following improve your condition? ☐Chiropractic ☐Rest ☐Recumbent ☐Sitting ☐Standing ☐Stretching ☐Massage ☐Medication ☐Nothing ☐ Other Have you had this complaint in the past? ☐ Yes ☐No If yes, when? _____ Have you seen any other healthcare providers for this current complaint? ☐ Yes ☐No	**Do any of the following improve your condition?** ☐Chiropractic ☐Rest ☐Recumbent ☐Sitting ☐Standing ☐Stretching ☐Massage ☐Medication ☐Nothing ☐ Other Have you had this complaint in the past? ☐ Yes ☐No If yes, when? _____ Have you seen any other healthcare providers for this current complaint? ☐ Yes ☐No	**Do any of the following improve your condition?** ☐Chiropractic ☐Rest ☐Recumbent ☐Sitting ☐Standing ☐Stretching ☐Massage ☐Medication ☐Nothing ☐ Other Have you had this complaint in the past? ☐ Yes ☐No If yes, when? _____ Have you seen any other healthcare providers for this current complaint? ☐ Yes ☐No

SECTION 3

Healthy Habits & Lifestyle

EXERCISE	DIET	ALCOHOL/TOBACCO/RECREATIONAL DRUG USE?
Do you exercise? ☐ Yes ☐No How often do you exercise? _____Days/week _____Hours/day Stretching/Flexibility ☐ Yes ☐ No Running/Walking ☐ Yes ☐ No Rowing/Swimming ☐ Yes ☐ No Competitive Athlete ☐ Yes ☐ No Pilates/Yoga ☐ Yes ☐ No Group Exercise ☐ Yes ☐ No Weight Lifting ☐ Yes ☐ No Other:_____ _____	Do you have a healthy diet? ☐ Yes ☐ No How many servings of fruits & vegetables per day? #_____ How many 8oz glass of water per day? #_____ Do you drink caffeinated beverages? ☐ Yes ☐ No How many per day? #_____ Do you have any food allergies? _____ _____ Have you ever had an eating disorder? ☐ Yes ☐ No	Do you use any of the above? ☐ Yes ☐ No How many cigarettes do you smoke? _____/day or _____/week Do you use smokeless tobacco? ☐ Yes ☐ No If Yes, How much do you use a day? Cans or pouches _____/day Do you have history of alcohol use? ☐Yes ☐No # drinks _____/day _____/wk (1 drink is equal to 12oz can of beer, 1.5oz liquor, 80 proof, 5 oz wine)
SLEEPING PATTERN Hours of sleep per night? ____hrs How is the quality of sleep? Excellent Good Fair Poor Sleep interrupted _____x/night	**DAILY STRESS LEVEL SCALE** **Low** **HIGH** 0 1 2 3 4 5 6 7 8 9 10 Have you ever sought help for a mental health issue? ☐Yes ☐No	This space intentionally blank.

SECTION 4

Personal Health –please mark all issues you have currently or in the past. **C=Current P=Past**

MUSCLE/JOINT			EARS/EYES/THROAT			SKIN			CARDIOVASCULAR			GENERAL		
Arthritis	C	P	Thyroid	C	P	Easy Bruising	C	P	Blood Pressure	C	P	Food Allergy	C	P
Back Pain	C	P	Hearing Difficulty	C	P	Psoriasis/Eczema	C	P	Irregular Heart Beat	C	P	Dizziness	C	P
Sciatic Pain	C	P	Vision	C	P	Hives	C	P				Infections	C	P
Bursitis	C	P				Skin Allergy	C	P	Poor Circulation	C	P			
Hip Pain	C	P	**DIGESTIVE**			Itching	C	P				**INFECTIOUS DISEASE**		
Foot Pain	C	P	Stomach	C	P	Varicose	C	P	**URINARY**			HIV	C	P
Neck Pain	C	P	Intestinal	C	P	PULMONARY	C	P	Kidney	C	P	Hepatitis	C	P
Headache	C	P	Colon	C	P	Difficulty Breathing	C	P	Difficulty Urinating	C	P	Tuberculosis	C	P
Shoulder Pain	C	P												
Arm Pain	C	P	**INTERNAL**			COPD	C	P	**REPRODUCTION**			**ENDOCRINE**	C	P
Wrist Pain	C	P	Liver	C	P	Asthma	C	P	Menstrual	C	P			
			Gall Bladder	C	P	Seasonal Allergy	C	P	Pregnancy	C	P	**NEUROLOGICAL**	C	P
			Pancreas	C	P				Prostate	C	P			
									Venereal Disease	C	P	**PSYCHOLOGICAL**	C	P

SECTION 4 con't

Medications:

Please list all of the medications you are taking including over the counter, herbs & vitamins and nutritional supplements. If none please write: NONE

Name/Dose/Frequency

Name/Dose/Frequency

Medication Allergies: Please list all allergies to medications: _____

SECTION 5

Accidents, Surgeries, Hospitalizations

Please list all accidents including motor vehicle accidents, injuries, surgeries & hospitalizations. Please include dates for each.

Accidents, Injuries, broken bones_____

Surgeries_____

Hospitalizations_____

Please list all of your doctors and healthcare providers including previous chiropractors:

Name:_____ Phone #:_____

Name:_____ Phone #:_____

Name:_____ Phone #:_____

SECTION 6

FAMILY HISTORY-Please mark the appropriate box with an X.

HISTORY	MOTHER	FATHER	SIBLING	GRANDMOTHER	GRANDFATHER
Diabetes	☐	☐	☐	☐	☐
Heart Problems	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐
Kidney Problems	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Auto Immune Disease	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐