David Byers, D.C. **Byers Family Chiropractic**

Patient Name: _____ **Date:** _____

Address _____ City _____ State _____ Zip Code _____

H. Phone _____ W. Phone _____ Cell Phone _____

Email Address: _____

Sex M F Marital Status M S D W Date of Birth _____ Age _____

Occupation _____

Employer _____

Who may we thank for referring you to our office? _____

Is this visit going to be for you or your family? Family Myself

Is this visit for a specific complaint or wellness care? Specific complaint Wellness care

Have you ever received Chiropractic care? Yes No If yes, when? _____ Any X-Rays? _____

Name of most recent Chiropractor: _____

1. Reasons for seeking chiropractic care:

Primary reason:

_____

Secondary reason:

_____

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:

_____

_____

_____

3. Past Health History:

A. Previous illnesses you've had in your life:

_____

B. Previous Injury or Trauma:

_____

Have you ever broken any bones? Which?

_____

C. Allergies:

_____

D. Medications:

Medication Reason for taking

_____

_____

_____

_____

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Patient Name: _____ **Date:** _____

E. Surgeries:

Date Type of Surgery

_____

_____

_____

_____

F. Females: Pregnancies and outcomes:

Pregnancies Date of Delivery Outcome

_____

_____

_____

_____

4. Family Health History:

Associated health problems of relatives:

_____

_____

_____

Deaths in immediate family:

Cause of parents or siblings death Age at death

_____

_____

_____

5. Social and Occupational History:

A. **Job description:**

_____

B. Work schedule:

_____

C. Recreational activities:

_____

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to **Byers Family Chiropractic** for services performed.

Patient or Guardian Signature _____ Date _____

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Patient Name: _____ **Date:** _____

NEW PATIENT HISTORY FORM

Symptom 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:

5% 10% 15% 20% 25% 30% 35% 40% 45% 50% 55% 60% 65% 70% 75% 80% 85% 90% 95% 100%

- When did the symptom begin? _____
  - o Did the symptom begin suddenly or gradually? (circle one) Sudden Gradual
  - o How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  - o Bending forward, bending backward, tilting to left, tilting to right, turning to left, turning to right, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
  - o Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - o Sharp, dull , achy, burning, throbbing, piercing, shooting, stabbing, nagging, deep, superficial, pin-point pain, generalized area of pain, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): Yes No
  - o If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one): Day Night
  - o Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:

5% 10% 15% 20% 25% 30% 35% 40% 45% 50% 55% 60% 65% 70% 75% 80% 85% 90% 95% 100%

- When did the symptom begin? _____
  - o Did the symptom begin suddenly or gradually? (circle one) Sudden Gradual
  - o How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  - o Bending forward, bending backward, tilting to left, tilting to right, turning to left, turning to right, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
  - o Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - o Sharp, dull , achy, burning, throbbing, piercing, shooting, stabbing, nagging, deep, superficial, pin-point pain, generalized area of pain, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): Yes No
  - o If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one): Day Night
  - o Morning Afternoon Evening Night Unaffected by time of day

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NEW PATIENT HISTORY FORM

Symptom 3 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:

5% 10% 15% 20% 25% 30% 35% 40% 45% 50% 55% 60% 65% 70% 75% 80% 85% 90% 95% 100%

- When did the symptom begin? _____
  - o Did the symptom begin suddenly or gradually? (circle one) Sudden Gradual
  - o How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  - o Bending forward, bending backward, tilting to left, tilting to right, turning to left, turning to right, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
  - o Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - o Sharp, dull , achy, burning, throbbing, piercing, shooting, stabbing, nagging, deep, superficial, pin-point pain, generalized area of pain, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): Yes No
  - o If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one): Day Night
  - o Morning Afternoon Evening Night Unaffected by time of day

Symptom 4 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:

5% 10% 15% 20% 25% 30% 35% 40% 45% 50% 55% 60% 65% 70% 75% 80% 85% 90% 95% 100%

- When did the symptom begin? _____
  - o Did the symptom begin suddenly or gradually? (circle one) Sudden Gradual
  - o How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  - o Bending forward, bending backward, tilting to left, tilting to right, turning to left, turning to right, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
  - o Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - o Sharp, dull , achy, burning, throbbing, piercing, shooting, stabbing, nagging, deep, superficial, pin-point pain, generalized area of pain, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): Yes No
  - o If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one): Day Night
  - o Morning Afternoon Evening Night Unaffected by time of day

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NEW PATIENT HISTORY FORM

Symptom 5 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:

5% 10% 15% 20% 25% 30% 35% 40% 45% 50% 55% 60% 65% 70% 75% 80% 85% 90% 95% 100%

- When did the symptom begin? _____
  - o Did the symptom begin suddenly or gradually? (circle one) Sudden Gradual
  - o How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  - o Bending forward, bending backward, tilting to left, tilting to right, turning to left, turning to right, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
  - o Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - o Sharp, dull , achy, burning, throbbing, piercing, shooting, stabbing, nagging, deep, superficial, pin-point pain, generalized area of pain, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): Yes No
  - o If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one): Day Night
  - o Morning Afternoon Evening Night Unaffected by time of day

Symptom 6 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:

5% 10% 15% 20% 25% 30% 35% 40% 45% 50% 55% 60% 65% 70% 75% 80% 85% 90% 95% 100%

- When did the symptom begin? _____
  - o Did the symptom begin suddenly or gradually? (circle one) Sudden Gradual
  - o How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  - o Bending forward, bending backward, tilting to left, tilting to right, turning to left, turning to right, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
  - o Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - o Sharp, dull , achy, burning, throbbing, piercing, shooting, stabbing, nagging, deep, superficial, pin-point pain, generalized area of pain, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): Yes No
  - o If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one): Day Night
  - o Morning Afternoon Evening Night Unaffected by time of day

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