APPLICATION FOR CARE AT NEWHOUSE HEALTH SOLUTIONS

Today's Date: ________________

PATIENT DEMOGRAPHICS

Name: ____
Birth Date: _____-_____-_____ Age: _______ __ Male __ Female Height ________ Wt.__________

Address: ____
City: ____ State: __________________ Zip: __________________
E-mail Address: ____
Home Phone: ____Fax:______________________________________
Mobile Phone: ____
Work Phone: ____ Fax: _____________________________________

Social Security #: ____
Driver's License #: ____ State: _________________________
Employer: ____
Occupation: ____

Name of Spouse: ____
Spouse's Employer: ____
Occupation: ____
Names and Ages of your children: ____
____

Name & Number of Emergency Contact: ____
Relationship: ____

Family Physician:__________________________ Phone number of Physician:______________________________

WOMEN ONLY: Are you pregnant or nursing? No_____ Yes_____

Who may we thank for referring you (How did you hear about us)? ___________________________

INSURANCE INFORMATION (Please list all sources of Insurance):

Patient's Insurance: ____

Employee ID# ________________________ Policy# ____

Group # ______________________________ Group Name: ____

Spouse' s Insurance: ____

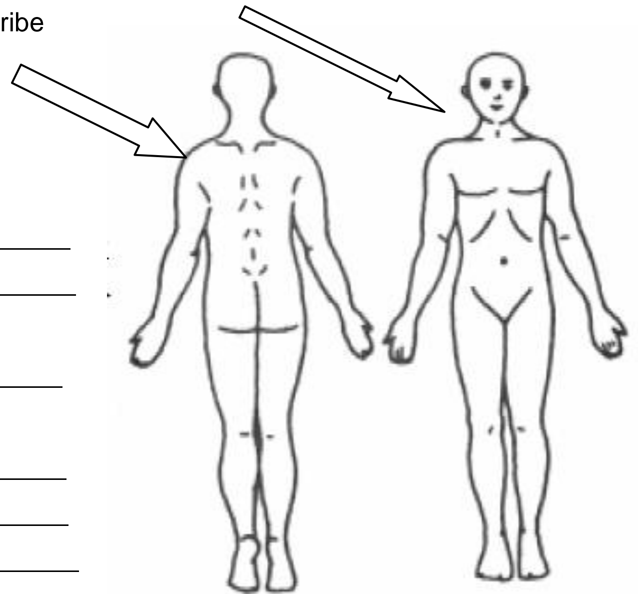
Other Insurance: ____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office:
Chief complaint:____
____
All Other problems or symptoms you are experiencing:
____
____
When did the problem(s) begin? ____________________ is your problem the result of ANY type of accident. __ Yes __ No
If yes identify type: __Auto __Work __Home__ Other (please explain): ____
Date of Accident: _______ - _______ - _ _____ approximately what time that day? ____am _____pm
Have you reported this accident to anyone? __ No __ Yes, if yes to whom: ____

Have you suffered with any of this or a similar problem in the past? __ No __ Yes If yes how many times? _______________
When was the last episode? __________________ Other forms of treatment tried? __No __ Yes
If yes, please state what type of treatment you have tried: ____,
and who provided it: ____
How long ago? ____
What were the results? __ Favorable __ Unfavorable→ please explain.
____

*PLEASE MARK the areas on the Diagram with the following letters to describe your symptoms:
R = Radiating B = Burning D = Dull A = Aching N = Numbness
S = Sharp/ Stabbing T= Tingling



When is the problem at its worst? __ AM __PM __mid-day __late PM

How long does it last? __ It is constant __ I experience it intermittently

What relieves your symptom(s)?_______________________________________

What makes them feel worse?____

Condition(s) ever been treated by anyone in the past? __No __ Yes

If yes, when:____ by whom? __________________________________

What were the results?

____

Name of Previous Chiropractor: ______________________________

How long were you under care: ____________ How long ago?_________

On a scale of 1 to 10 with10 being the worst pain and 0 being no pain, rate how you feel today (Circle the number):

Primary or chief complaint is	: 0	1	2	3	4	5	6	7	8	9	10
Second complaints is a	: 0	1	2	3	4	5	6	7	8	9	10
Third complaint	: 0	1	2	3	4	5	6	7	8	9	10

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? __ No __ Yes
   If yes whom: __ grandmother __grandfather __ mother __ father __ sister's __brother's __son(s) __daughter(s)
2. Have they ever been treated for their condition? __ No __Yes __I don't know
3. Any other hereditary conditions the doctor should be aware of. __ No __Yes: __________________________

SOCIAL HISTORY

1. Smoking: __cigars __ pipe __cigarettes How often? __Daily __Weekends __ Occasionally __ Never
2. Alcoholic Beverage: consumption occurs __ Daily __ Weekends __ Occasionally __ Never
3. Recreational Drug use: __ Daily __ Weekends __ Occasionally __ Never
4. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect the following:

IDENTIFY TYPE:	EFFECT:			
___________________________________	__No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
___________________________________	__No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
___________________________________	__No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
___________________________________	__No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform

PAST HISTORY

***FOR PRESENT CONDITIONS MARK "P", PAST CONDITIONS MARK "X" (3 MONTHS OR LONGER) (Please 'Circle' if necessary to be more specific)

___Numbness/Tingling/Pain in (Arms / hands/ fingers)
R / L Both

___Numbness, Tingling or Pain in (Buttocks/Thighs/Legs/Feet/Toes)
R / L Both

___Headaches/Migraines	___Hip Pain R / L	___Neck Stiffness/ Pain	___Back Stiffness/Pain
___Fractured Bones	___Arthritis	___Frequent Colds / Flu	___Diabetes
___Swollen Painful Joints	___Convulsions/Epilepsy	___Skin Problems	___Asthma/Emphysema
___Anemia	___Tremors	___Blurred Vision R / L	___Double Vision R / L
___Pain w/ Cough / Sneeze	___Chest Pain	___Lung Problems	___Loss of Taste
___Heart Problems	___Stroke	___Gall Bladder Problems	___Digestive Problems
___Prostate Problems	___Kidney Trouble	___Loss of Smell	___Loss of Balance
___Dizziness/Vertigo	___Buzzing/Ringing in ears	___Sinus Problems	___Nervousness/Anxiety
___Fatigue	___Depression	___ Irritability/Mood Swings	___Tension/Stress
___Colon Trouble	___Sleeping Problems	___Cold Hands	___Stomach Upset
___Cold feet	___Bed Wetting	___Recurring Infection	___Diarrhea/Constip./Gas
___Foot Problems	___Shortness of Breath	___Hot Flashes	___Jaw/TMJ Problems
___Cold Sweats	___Light Bothers Eyes	___Problems Urinating	___Heartburn/Reflux
___High Blood pressure	___PMS	___Menopause	___Ulcers
___Other ________________	___Thyroid Problems	___Allergies	___ Cancer (Type)_________________

___Previous Surgeries:____

Additional Explanation: ____

____

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

_____ACTIVITIES:	EFFECT:			
Carrying Groceries	__ No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Sit to Stand	__ No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Climbing Stairs	__ No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Pet Care	__ No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Driving	__ No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Extended Computer Use	__ No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Household Chores	__ No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Lifting Children	__ No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Reading/Concentration	__ No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Bathing	__ No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Dressing	__ No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Shaving	__ No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Sexual Activities	__ No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Sleep	__ No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Sitting	__ No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Standing	__ No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Yard work	__ No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Walking	__ No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Sweeping/Vacuuming	__No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Dishes	__No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Laundry	__No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Garbage	__No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Other: ______________	__No Effect	__Painful (can do)	__ Painful (limits)	__Unable to Perform