

Cornerstone Chiropractic

New Patient Information

Patient Name _____ Date _____

Last Name First Name Middle Initial

Address _____

Sex M F Birth date _____ Age _____

Married Single Widowed Minor Separated Divorced Partnered for _____ years

Employer _____ Occupation _____

Spouse's Name _____

Whom May We Thank For Referring You? _____

Contact Information

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Which number do you prefer we use? _____

In case of emergency, contact _____ using this number (____) _____

Relationship to you _____

Is Your Treatment for:

Auto Injury L&I Worker' Comp. Chronic Condition Other _____

Present Condition

Reason for visit _____

When did your symptoms appear? _____

What brought on your symptoms? _____

Getting Worse Getting Better Staying the same?

Mark an X on the picture where you have had pain

Mark an N on the picture where you have had numbness/tingling

Type of pain:

Aching Annoying Burning Dull Pulling Sharp Stiff

Numb Tingly Tight "shock" like

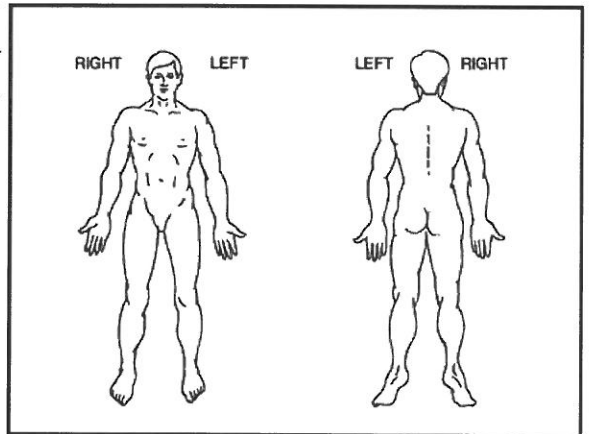
How often do you get this pain?

Constant (76-100% of the time) Frequent (51-76% of the time)

Occasional (26-50% of the time) Intermittent (1-25% of the time)

Rate the severity of your symptom from 0 (no symptoms) to 10 (worst ever) _____

Rate all other symptoms (if you don't rate them, we will assume a 5 on a 0-10 scale)



Aggravated by... Bathing Bending Carrying Climbing Stairs Computer Use
 Coughing/Sneezing Driving Getting up from sitting Laying Down Lifting Reaching Running
 Sitting Standing Stress Twisting Walking Working Yard Work

Health History

Height ___ft. ___in Weight _____ lbs

My overall health is... Excellent Very Good Good Fair Poor

I would describe my exercise activity as... Strenuous Moderate Light None

My work activity involves mostly...

Sitting Standing Computer Work Phones Driving Manual Labor

Are you Pregnant? Yes No Due Date _____

Medications	Surgeries (type and year)	Falls/Accidents/Injuries	Supplements

Do you Smoke? No Yes _____Packs/Day

How much water do you drink per day? _____ oz. / liters