Hamel Family Chiropractic

50 Cretin Ave S

Saint Paul, MN 55105

New Patient Information

Date_____

Name_____ Date of Birth_____Age _____

Address_____ City_____State_____ Zip_____

Home Phone # _____ Work # _____ Cell # _____

E-mail address_____

Your employer_____Your Position _____

Spouses/Partners Name_____Ages of children_____

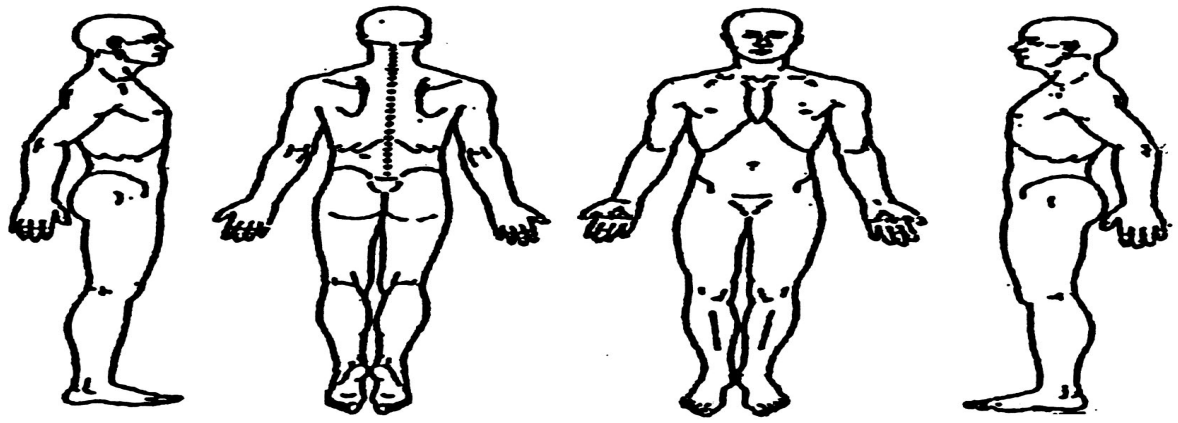
How will payment be made: ❑ Cash/Check ❑ Credit Card ❑ Auto Ins. ❑ Work Comp

Whom may we thank for referring you to our clinic?_____

Would you be interested in a complimentary nutrition consultation? (circle one) YES NO MAYBE

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. Your MAIN complaint: (circle) Neck Mid- Back Lower Back Other_____

4. Using a scale from 0-10 (10 being the worst), how would you rate your MAIN Complaint?

0 1 2 3 4 5 6 7 8 9 10 *(circle)*

5. Your Secondary complaint: (circle) Neck Mid- Back Lower Back Other_____

6. Using a scale from 0-10 (10 being the worst), how would you rate your Secondary Complaint?

0 1 2 3 4 5 6 7 8 9 10 *(circle)*

7. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)

□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

8. How would you describe the type of pain?

□ Sharp	□ Numb	□ Achy	□ Shooting with motion
□ Dull	□ Tingly	□ Burning	□ Stabbing with motion
□ Diffuse	□ Sharp with motion	□ Stiff	□ Other:_____
□ Shooting	□ Electric with motion		

9. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

10. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

11. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

12. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician

□ ER physician □ Orthopedist □ Other:_____

□ Massage Therapist □ Physical Therapist □ No one

13. How long have you had this problem? _____

14. How do you think your problem began?

_____

15. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

16. What aggravates your problem?

_____

19. What concerns you the most about your problem; what does it prevent you from doing?

_____

20. What is your: Height_____ Weight _____

21. How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

22. What type of exercise do you do?

□ Strenuous □ Moderate □ Light □ None

23. Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis □ Diabetes □ Lupus

□ Heart Problems □ Cancer □ ALS

24. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependence
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Depression	□	□ Kidney Disorders	□	□ Elbow/Upper Arm Pain
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus

□ □ Hand Pain □ □ Painful Urination □ □ Epilepsy

□ □ Hip Pain □ □ Loss of Bladder Control □ □ Dermatitis/Eczema/Rash

□ □ Upper Leg Pain □ □ Prostate Problems □ □ HIV/AIDS

□ □ Knee Pain □ □ Ulcer □ □ Muscular In-coordination

□ □ Ankle/Foot Pain □ □ Loss of Appetite **For Females Only**

□ □ Jaw Pain □ □ Abdominal Pain □ □ Birth Control Pills

□ □ Joint Pain/Stiffness □ □ Tumor □ □ Hormonal Replacement

□ □ Arthritis □ □ Hepatitis □ □ Pregnancy

□ □ Rheumatoid Arthritis □ □ Liver/Gall Bladder Disorder

□ □ Cancer □ □ General Fatigue

□ □ Abnormal Weight Gain/Loss

□ □ Asthma □ □ Visual Disturbances

□ □ Chronic Sinusitis □ □ Dizziness

□ □ Other:_____

25. List all prescription medications/over-the-counter medications you are currently taking:

_____

26. List all of the nutritional supplements you are currently taking:

_____

27. List all surgical procedures you have had:

_____

28. What activities do you do at work?

□ **Sit:** □ Most of the day □ Half the day □ A little of the day

□ **Stand:** □ Most of the day □ Half the day □ A little of the day

□ **Computer work:** □ Most of the day □ Half the day □ A little of the day

□ **On the phone:** □ Most of the day □ Half of the day □ A little of the day

29. What activities do you do outside of work?

_____

30. Have you ever been hospitalized? □ No □ Yes

if yes, why _____

31. Have you had significant past trauma? □ No □ Yes

32. Have you had chiropractic care in the past? □ No □ Yes

Results _____

33. Anything else pertinent to your visit today?

_____

Patient Signature_____ **Date:**_____