NEW PATIENT EVALUATION FORM

Name: _____ Occupation: _____

Leisure Activities: _____

Height: _____ Weight: _____pounds

MEDICATIONS:
List any medications you are currently taking:
_____

Are you allergic to bees wax or coconut oil?_____
Have you declared the Advanced Clinical Directive of Do Not Resuscitate? _____

Please check (√) below if you are being seen by any of the following providers.

- ☐ Medical Doctor (MD)
- ☐ Osteopath
- ☐ Dentist
- ☐ Psychiatrist/Psychologist
- ☐ Neurologist
- ☐ Chiropractor
- ☐ Acupuncturist
- ☐ Orthopedic Surgeon
- ☐ Other:_____

Check (√) below if you have **EVER** been diagnosed as having any of the following conditions?

- ○ Kidney Disease
- ○ High Blood Pressure
- ○ Asthma
- ○ PACEMAKER/DEFIBULATOR
- ○ Diabetes
- ○ Rheumatoid Arthritis
- ○ Autoimmune Disorder
- ○ Depression/Anxiety
- ○ Tuberculosis
- ○ Blood Clots
- ○ AIDS/HIV
- ○ Artificial Joints
- ○ Circulation Problems
- ○ Stomach Ulcers
- ○ Thyroid Problems
- ○ Other conditions we should be aware of? _____
- ○ Multiple Sclerosis
- ○ Osteoarthritis/Osteopenia
- ○ Stroke
- ○ Hepatitis
- ○ Hearing Loss
- ○ Raynaud's
- ○ Epilepsy
- ○ Celiac Disease
- ○ Food sensitivities
- ○ Urinary Tract Infections, Stones
- ○ Skin Lesions or Rash
- ○ Communicable Disease (Hepatitis, TB, etc.)
- ○ Cancer –
  If yes, what kind?_____

Family History: Has anyone in your family (parents/brothers/sisters/grandparents,etc) been treated for the following? Please check (√) below all that apply:

- ○ Diabetes
- ○ Stroke
- ○ Cancer
- ○ Depression
- ○ Heart Disease
- ○ High Blood Pressure
- ○ Alcoholism
- ○ Kidney Disease
- ○ Inflammatory Arthritis (Rheumatoid, Ankylosing)
- ○ Osteoarthirits

SURGERIES/HOSPITALIZATIONS: Please list any surgeries or other conditions that you may have been hospitalized within the past 5 years with approximate dates and reasons:

Date_____Reason:_____
Date_____Reason:_____

PREVIOUS INJURIES AND DATES: (falls, car accidents, fractures, concussions, etc)

Date_____Injury:_____
Date_____Injury:_____

Please check (√) below any *symptoms* that you are currently experiencing that are **new**, **atypical, unusual**.

- ☐ Unexplained weight loss/gain
- ☐ Nausea/vomiting
- ☐ Dizziness
- ☐ Fatigue
- ☐ Blood in stools
- ☐ Difficulty breathing/ shortness of breath
- ☐ Consistent cough
- ☐ Fever/chills/sweats
- ☐ Double vision
- ☐ Numbness/tingling
- ☐ Weakness
- ☐ Insomnia
- ☐ Difficulty swallowing
- ☐ Memory loss/change in mentation
- ☐ Night Pain
- ☐ Chest Pain

SOCIAL HISTORY:

How much alcohol do you consume per day? _____

How much caffeinated beverages do you consume per day?_____

How many cigarettes do you smoke per day?_____How many years?_____

Do you live alone? _____ Any Children? If so, How many? _____

ONSET of PAIN/DECREASE IN FUNCTION:

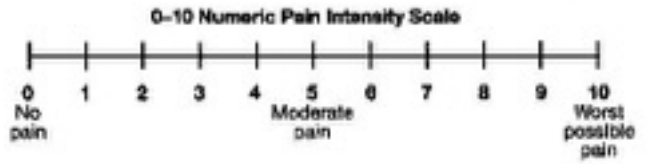
How long ago did your pain or decrease in function begin?_____

Are you currently experiencing any headaches?_____Frequency?_____

Any falls in the last year?_____

PAIN: Please ***Circle*** Pain Description and Number of Pain in the last week

Stabbing	Prickling
Ache	Numbness
Burning	Tingling
Sharp	Sore
Tender	Shock/Zap



Is your pain constant or intermittent?

Please mark the locations of your current pain/symptoms on the diagrams below