New Patient Information

I would like to welcome you to my office. Most likely someone recommended that you come and see me. Word of mouth has been the way most of our patients have come to us since 1991. I will do my very best to honor the person who referred you to me by treating you the way I would like to be treated if our positions were reversed. This all starts with me having an extensive understanding of your problem. If you would be so kind as to fill this form out as best you can it will help me determine if I can help you or if I need to refer you to someone who can. If there is important information that this form does not ask you about please take the liberty to write it on the back of the form. I will review this information just as soon as you are done and we will get started with getting you feeling better.

Thank you,

Darrell R. Kilcup, D.C. Today's Date: ____ / ____ / ______

Your Name: ____ [ ] Male [ ] Female

Nickname: ______________________ Date of Birth: ____ / ____ / ______

Age: _______ Social Security Number: ________-______-________

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated

Home Address: ____

City: _________________________________ State: _____ Zip: _____________

Home Phone: (____) ______________ Work Phone: (____) ________________

Mobile Phone: (____) ____________________ Email: _______________________

Employer: ____

Address: ____

City: _________________________________ State: _____ Zip: _____________

Spouses Name: _____________________ Spouses Occupation: ______________

Children: [ ] Yes [ ] No Age(s)____

Emergency Contact: _____________________ Phone: (____) ________________

Who can we thank for referring us to you:_________________________________

Can we contact him/her? [ ] Yes [ ] No

Patient Name: ______________________________ Date: _______________

New Patient History of Problems

1. List major complaints and symptoms please be as specific as you can.

____

____

____

____

2. How do you believe your problem (pain) began?

____

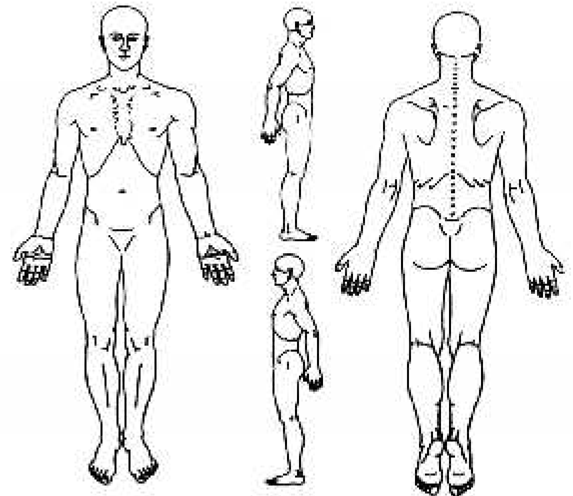
____

____

3. Have you ever had this or a similar condition before?__________________________

4. When? ____

5. Is today's problem a result of: Auto Accident Workman's Compensation Injury



First Complaint or Symptom Details

1. Indicate on the drawings where you have pain/symptoms

2. 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)

3. How would you describe the type of pain?

Sharp | Numb
Dull | Tingly
Diffuse | Sharp with motion
Achy | Shooting with motion
Burning | Stabbing with motion
Shooting | Electric like with motion
Stiff | Other:____________________

4. How are your symptoms changing with time?

Getting Worse Staying the Same Getting Better

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

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

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

Not at all A little bit Moderately Quite a bit Extremely

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

Not at all A little bit Moderately Quite a bit Extremely

8. Who else have you seen for your problem?

Chiropractor | Neurologist | Primary Care Physician
ER physician | Orthopedist | Other:______________
Massage Therapist | Physical Therapist | No one

9.How long have you had this problem? ____

10. How do you think this problem began?____

11.Do you consider this problem to be severe?

Yes Yes, at times No

12. What positions or activities aggravate your condition?__________________________________

Patient Name: ______________________________ Date: _______________

13. What positions or activities relieve your condition? ______________________________________

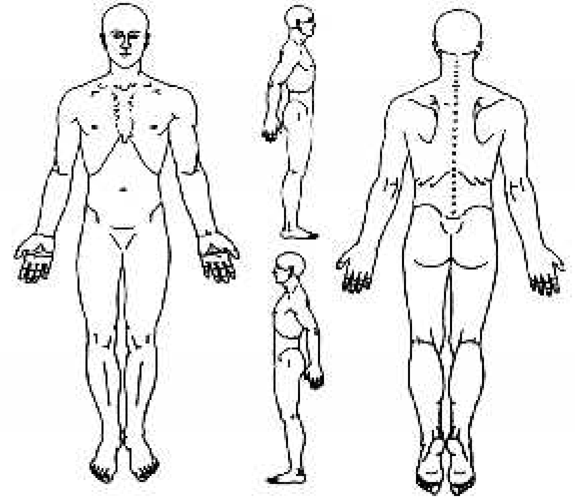
14. What concerns you the most about this problem?

It could be serious	It is affecting golf
It isn't going away	It is affecting sleep
It is affecting leisure activities	It is affecting mental outlook
It is affecting work	It is affecting relationships
It is getting worse	Other:

____

____

<u>Second Complaint or Symptom Details (Optional)</u>



1. Indicate on the drawings where you have pain/symptoms

2. 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)

3. How would you describe the type of pain?

Sharp	Numb
Dull	Tingly
Diffuse	Sharp with motion
Achy	Shooting with motion
Burning	Stabbing with motion
Shooting	Electric like with motion
Stiff	Other:__________________

4. How are your symptoms changing with time?

Getting Worse Staying the Same Getting Better

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

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

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

Not at all A little bit Moderately Quite a bit Extremely

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

Not at all A little bit Moderately Quite a bit Extremely

8. Who else have you seen for your problem?

Chiropractor	Neurologist	Primary Care Physician
ER physician	Orthopedist	Other:____________
Massage Therapist	Physical Therapist	No one

9.How long have you had this problem? ____

10. How do you think this problem began?____

11.Do you consider this problem to be severe?

Yes Yes, at times No

12. What positions or activities aggravate your condition?__________________________________

13. What positions or activities alleviates your condition?__________________________________

14. What concerns you the most about this problem?

It could be serious	It is affecting golf
It isn't going away	It is affecting sleep
It is affecting leisure activities	It is affecting mental outlook
It is affecting work	It is affecting relationships
It is getting worse	Other:

____

____

Patient Name: ______________________________ Date: _______________

Third Complaint or Symptom Details (Optional)

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

3. How would you describe the type of pain?

Sharp	Numb
Dull	Tingly
Diffuse	Sharp with motion
Achy	Shooting with motion
Burning	Stabbing with motion
Shooting	Electric like with motion
Stiff	Other:___________________

4. How are your symptoms changing with time?

Getting Worse Staying the Same Getting Better

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

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

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

Not at all A little bit Moderately Quite a bit Extremely

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

Not at all A little bit Moderately Quite a bit Extremely

8. Who else have you seen for your problem?

Chiropractor	Neurologist	Primary Care Physician
ER physician	Orthopedist	Other:_____________
Massage Therapist	Physical Therapist	No one

9. How long have you had this problem? ____

10. How do you think this problem began?____

11. Do you consider this problem to be severe?

Yes Yes, at times No

12. What positions or activities aggravate your condition?_____________________________________

13. What positions or activities alleviates your condition?_____________________________________

14. What concerns you the most about this problem?

It could be serious	It is affecting golf
It isn't going away	It is affecting sleep
It is affecting leisure activities	It is affecting mental outlook
It is affecting work	It is affecting relationships
It is getting worse	Other:

____

____

Fourth Complaint or Symptom Details (Optional)

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

Patient Name: ______________________________ Date: _______________

3. How would you describe the type of pain?

Sharp	Numb
Dull	Tingly
Diffuse	Sharp with motion
Achy	Shooting with motion
Burning	Stabbing with motion
Shooting	Electric like with motion
Stiff	Other:___________________

4. How are your symptoms changing with time?

Getting Worse   Staying the Same   Getting Better

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

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

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

Not at all   A little bit   Moderately   Quite a bit   Extremely

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

Not at all   A little bit   Moderately   Quite a bit   Extremely

8. Who else have you seen for your problem?

Chiropractor	Neurologist	Primary Care Physician
ER physician	Orthopedist	Other:_____________
Massage Therapist	Physical Therapist	No one

9.How long have you had this problem? ____

10. How do you think this problem began?____

11.Do you consider this problem to be severe?

Yes   Yes, at times   No

12. What positions or activities aggravate your condition?_________________________________

13. What positions or activities alleviates your condition?_________________________________

14. What concerns you the most about this problem?

It could be serious	It is affecting golf
It isn't going away	It is affecting sleep
It is affecting leisure activities	It is affecting mental outlook
It is affecting work	It is affecting relationships
It is getting worse	Other:

____

____

Fifth Complaint or Symptom Details (Optional)

1. Indicate on the drawings where you have pain/symptoms

2. 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)

3. How would you describe the type of pain?

Sharp	Numb
Dull	Tingly
Diffuse	Sharp with motion
Achy	Shooting with motion
Burning	Stabbing with motion
Shooting	Electric like with motion
Stiff	Other:___________________

4. How are your symptoms changing with time?

Getting Worse   Staying the Same   Getting Better

Patient Name: ______________________________ Date: _______________

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

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

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

Not at all A little bit Moderately Quite a bit Extremely

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

Not at all A little bit Moderately Quite a bit Extremely

8. Who else have you seen for your problem?

Chiropractor Neurologist Primary Care Physician
ER physician Orthopedist Other:______________
Massage Therapist Physical Therapist No one

9.How long have you had this problem? ____

10. How do you think this problem began?____

11.Do you consider this problem to be severe?

Yes Yes, at times No

12. What positions or activities aggravate your condition?__________________________________

13. What positions or activities alleviates your condition?__________________________________

14. What concerns you the most about this problem?

It could be serious It is affecting golf
It isn't going away It is affecting sleep
It is affecting leisure activities It is affecting mental outlook
It is affecting work It is affecting relationships
It is getting worse Other:

____

____

Patient Name: ______________________________ Date: _______________

New Patient Past Medical, Social, Work, and Family History

1. What is your: Height_____________ Weight ______________ Date of Birth ____________________

Occupation ____

2. How would you rate your overall Health?

Excellent Very Good Good Fair Poor

3. What type of exercise do you do?

Strenuous Moderate Light None

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

Rheumatoid Arthritis Diabetes Lupus

Heart Problems Cancer ALS

5. 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
		Elbow/Upper Arm Pain			Kidney Disorders			Depression
		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			Abnormal Weight Gain/Loss			
		Ankle/Foot Pain			Loss of Appetite			For Females Only
		Jaw Pain			Abdominal Pain			Birth Control Pills
		Joint Pain/Stiffness			Ulcer			Hormonal Replacement
		Arthritis			Hepatitis			Pregnancy
		Rheumatoid Arthritis			Liver/Gall Bladder Disorder			
		Cancer			General Fatigue			
		Tumor			Muscular Incoordination			
		Asthma			Visual Disturbances			
		Chronic Sinusitis			Dizziness			
		Other:__________________________						

6. List all prescription medications you are currently taking:

____

7. List all of the over-the-counter medications you are currently taking:

____

8. List all of the supplements you are currently taking:

____

9. List all surgical procedures you have had:

____

Patient Name: ______________________________ Date: _______________

10. 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

Drives: Most of the day Half the day A little of the day

Manual labor: Most of the day Half the day A little of the day

Reads a lot: Most of the day Half the day A little of the day

Travels frequently: Most of the day Half of the day A little of the day

11. What activities do you do outside of work?

____

12. Have you ever been hospitalized? No Yes

if yes, why ____

13. Have you seen a Chiropractor before? No Yes How long ago?_____________________________

What were the results of the care?____

14. Have you had significant past trauma? No Yes

if yes, please describe:____

15. Anything else pertinent to your visit today?_______________________________________

Patient Signature______________________________ Date:____________________