New Patient History Form

Welcome to SA Chiropractic Clinic
Please take a few moments to fill out this form as complete as possible.

Please Print:
Name:_____Date:_____
Phone no: Home_____Work_____Cell_____
Address:_____
City:_____Code:_____
Date of Birth_____Age:_____ID no:_____
Marital Status:_____Number of Children:_____
Occupation:_____
Medical Aid:_____Medical Aid ID no:_____

Who may we thank for referring you?_____
Have you ever had Chiropractic care?_____If yes, when?_____

List your chief complaints in order of severity:
1._____For how long?_____
2._____For how long?_____
3._____For how long?_____

What do you do for fun? (sports, hobbies, etc.)_____
If female, are you pregnant?_____
Are you taking prescription/non-prescription drugs?_____
Have you ever had any operations?_____
Have you ever been in an accident/serious injury?_____
Do you have any heart problems/strokes/clogged arteries?_____

We provide monthly healthy living newsletters, updates, and reminders, would you like to be put on our subscribers list? YES No
Email address:_____

Habits: These practices influence your body's ability to heal and respond favorably to care.

Alcohol Drinks/weekly___	Exercise Daily Weekly None			None	Some	Moderate
Coffee cups/daily___	Sleep ≤4hrs 4-6hrs ≥8hrs	Water		O	O	O
Tobacco pks/daily___	Meals 1/day 2/day ≥3day	Sugar foods		O	O	O
Drugs/Recreational Yes No	Soda none 1-2 ≥3					

Please check any of the following symptoms/conditions that you have had in the past/present.

___Headaches ___Carpal Tunnel ___Asthma ___Digestive Problems
___Neck Pain ___Problem Sleeping ___Vertigo ___Pain between Shldr Blades
___Mid Back Pain ___Ringing in Ears ___Cancer ___Shortness of Breath
___Low Back Pain ___Loss of Balance ___Allergies ___Tension across Top of Shldrs
___Sciatic Pain ___High Blood Pressure ___Dizziness ___Numbness in Arms/Legs
___Leg/Hip Pain ___Weight Trouble ___Depression ___Menstrual Pain
___Shldr/Arm Pain ___Low Energy/Fatigued ___Other_____