Lynch Chiropractic and
Chronic Pain Solutions
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NEW PATIENT INFORMATION

Welcome! Please allow our staff to photocopy your Driver's License and Insurance card(s) (if applicable).

PLEASE PRINT CLEARLY.

Full Name: _____ **Gender**: ☐M ☐F **Age**:____ **Birth Date**: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Social Security#: _____-_____-_____ **E-mail** _____ **Home Phone**: (_____) _____

Marital Status: ☐S ☐M ☐D ☐W **# of Children**:____ **Work Status**: ☐Full time ☐Part-time ☐Retired **Cell**: (_____) _____

Females: Last Menstrual Period: _____ **Pregnant?** ☐Y ☐N **Nursing?** ☐Y ☐N **Fax**: (_____) _____

Employer: _____ **Occupation**: _____ **Work Phone**: (____) _____

Name of Spouse, Parent or Guardian: _____ **Age**: _____ **Birth Date**: _____ **SS#:** _____-_____-_____

Spouse's Employer: _____ **Spouse's Occupation**: _____ **Work Phone**: (____) _____

In case of an Emergency Contact: _____ **Relationship**: _____

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

Do you have <u>Medicare</u> Insurance? ☐Y ☐N

Who may we thank for referring you? _____

May we send your referrer a thank you note?_____

Appointment reminders and private health information will be communicated to you only in the manners in which you have given specific written authorization and you have the option to opt out of any of those methods at any time by notifying our office. Email and standard SMS/text messaging are not confidential methods of communication and may be insecure.

We may use and disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your personal health information (PHI), as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your PHI for other internal marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer, by initialing below we are asking you for your authorization. You may contact our Privacy Officer to request that these materials not be sent to you at any time. Our privacy officer is Terry Lynch.

By initialing here _____ you give Lynch Chiropractic and Chronic Pain Solutions permission to email you.

By initialing here _____ you give Lynch Chiropractic and Chronic Pain Solutions permission to mail you.

By initialing here _____ you give Lynch Chiropractic and Chronic Pain Solutions permission to text you.

By initialing here _____ you give Lynch Chiropractic and Chronic Pain Solutions permission to call you at

_____ phone number(s).

You will be given a Notice of Patient Privacy Policy and will be requested to sign a Consent to use PHI stating we have given a copy to you.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ _____ Date: _____

HEALTH CONCERNS: Please list your top health concerns in order of priority.

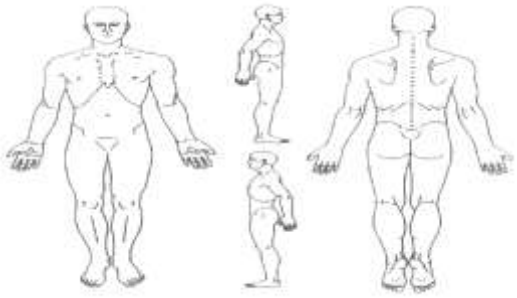
1) _____
2) _____
3) _____
4) _____

TREATMENT: What type of treatment are you looking for?

☐ I am looking for the most minimal amount of care to "patch up the symptoms" of my problem.
☐ I am looking to resolve my symptoms and then go on to "fix the cause" of my problem.
☐ I am looking to take care of my problem and then go on to "achieve optimal health and wellness."
☐ I would like to take a "Health and Wellness Evaluation" survey to find if there are any other contributing factors causing spinal misalignment.

Please mark on the diagram to the right the following symbols as they relate to the patients' symptoms:

SS = spasms ST = stiffness
DP = dull pain SP = sharp pain
SH = shooting pain TI = tingling
NU = numbness O = Other



COMPLAINT/PROBLEM: In relation to your primary complaint:

When did you first seek treatment for this problem? _____ Has another doctor(s) treated you for this condition: ☐Y ☐N

Whom? ☐MD ☐DO ☐DC ☐DDS ☐Other: _____ Name of primary doctor?_____

Treatment(s) Tried:☐Medication ☐Surgery ☐Lifestyle change ☐ Chiropractic ☐ other_____

Have you had any intolerance or reactions to treatments? ☐Y ☐N Describe: _____

When did the problem start ?: _____ How did it originally occur? _____

Has it become worse recently? ☐Y ☐N ☐Same ☐Better ☐Gradually worse How frequent is the condition? ☐Constant ☐Daily ☐Intermittent

How long does it last? ☐All day ☐Few hours ☐Minutes Is this condition interfering with your? ☐Work ☐ Sleep ☐Daily routine ☐Recreation

Does anything relieve the symptom(s)? ☐Y ☐N ☐ Medication(prescription or OTC) ☐Rest ☐Exercise/Stretch ☐ Other: _____

If no, what have you tried? ☐ Medication (prescription or OTC) ☐Rest ☐Exercise/Stretch ☐ Surgery

Is there anything that you can do to relieve the symptom? ☐Y ☐N ☐ Medication(prescription or OTC) ☐Rest ☐Exercise/Stretch ☐ Other: _____

If no, what have you tried to do that has not helped? ☐ Medication (prescription or OTC) ☐Rest ☐Exercise/Stretch ☐ Surgery ☐Chiropractic

☐Other:_____

How long has it been since you really felt good? ☐Days ☐Weeks ☐Months ☐Years ☐ >10 years

Describe the pain/problem: ☐Sharp ☐Dull ☐Numbness ☐Tingling ☐Aching ☐Burning ☐Stabbing ☐Other: _____

What makes the problem worse? ☐Standing ☐Sitting ☐Lying ☐Bending ☐Lifting ☐Twisting ☐Other: _____

What do you believe is cause of the problem?_____

Are there any other conditions or symptoms that may be related to your major symptom? ☐Y ☐N If yes, what?

Please check all of the symptoms that apply. (**P**=Past / **C**= Current)

P / C	P / C	P / C	P / C	P / C
☐ ☐ Headache	☐ ☐ High Blood Pressure	☐ ☐ Tingling in Feet	☐ ☐ Facial Pain	☐ ☐ Low Blood Pressure
☐ ☐ Walking Problems	☐ ☐ Eye Pain	☐ ☐ Abdominal Pains	☐ ☐ Sore Muscles	☐ ☐ Blurred Vision
☐ ☐ Nausea/Vomiting	☐ ☐ Weak Muscles	☐ ☐ Dizziness	☐ ☐ Poor Appetite	☐ ☐ Paralysis
☐ ☐ Earache	☐ ☐ Fullness of Bladder	☐ ☐ Shakiness	☐ ☐ Forgetfulness	☐ ☐ Urination Difficulty
☐ ☐ Sweating	☐ ☐ Confusion	☐ ☐ Frequent Urination	☐ ☐ Insomnia	☐ ☐ Sinusitis
☐ ☐ Constipation	☐ ☐ Fainting	☐ ☐ Teeth Grinding	☐ ☐ Hemorrhoids	☐ ☐ Convulsions
☐ ☐ Dry Mouth	☐ ☐ Decreased Sex Drive	☐ ☐ Irritability	☐ ☐ Excessive Thirst	☐ ☐ Menstrual Irregularities
☐ ☐ Impatience	☐ ☐ Unpleasant Taste	☐ ☐ Elbow / Hand Pain	☐ ☐ Fatigue	☐ ☐ Neck Pain
☐ ☐ Tingling in Hands	☐ ☐ Feel Loss of Control	☐ ☐ Sore Throat	☐ ☐ Clammy Hands	☐ ☐ Lump in Throat
☐ ☐ Low Back Pain	☐ ☐ Swallowing Pain	☐ ☐ Hip Pain	☐ ☐ Unsteady Voice	☐ ☐ Knee Pain
☐ ☐ Shoulder Pain	☐ ☐ Poor Circulation	☐ ☐ Persistent Coughing	☐ ☐ Swollen Joints	☐ ☐ Chest Pressure
☐ ☐ Joint Stiffness	☐ ☐ Slow Heart Rate	☐ ☐ Swollen Ankles	☐ ☐ Rapid Heart Rate	☐ ☐ Ankle / Foot Pain
☐ ☐ Other:_____				

Patients Name: _____Date: _____

ALLERGIES/Sensitivities: Please check and list all allergies.

☐ Food: ☐Dairy ☐Wheat ☐Corn ☐Soy ☐Seafood ☐Gluten ☐Peanuts ☐Fruits ☐Other: _____

☐ Medications: ☐Penicillin ☐Sulfa Drugs ☐Iodine ☐Insulin ☐Antibiotics ☐Other:_____

☐ Seasonal/Other: ☐Pollen ☐Dust ☐Hay ☐Mold ☐Chemical(s) ☐Smoke ☐ Animals ☐Insects ☐Other:_____

MEDICATIONS: Please check and list all medications that you are currently taking with the date you began taking them.

	Medication Name	Date Started
☐ Antacids		
☐ Antibiotics		
☐ Antidepressants		
☐ Anti-Diabetics		
☐ Anti-Inflammatory		
☐ Blood Pressure Lowering Meds.		
☐ Cholesterol Lowering Meds.		
☐ Hormone Replacements (HRT)		
☐ Oral Contraceptives		
☐ OTC (over the counter) Other		

SUPPLEMENTS: Do you take Vitamins/Supplements or Herbs? ☐Y ☐N If yes, who recommended them? _____

SCARS / SURGICAL PROCEDURES: Have you had any surgical procedures? ☐YES ☐NO Any Scars? ☐YES ☐NO

SPINE: ☐Cervical ☐Thoracic ☐Lumbar EXTREMITIES: ☐Shoulder/Elbow/Hand/Wrist☐R☐L ☐Hip/Knee/Ankle/Foot ☐R☐L

ABDOMINAL/CHEST: ☐Appendix ☐Colon ☐Gall Bladder ☐Heart ☐Lungs ☐Breast ☐Other:_____

HABITS:

	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Soda / Diet Soda	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Stress Level	☐	☐	☐	☐

	5-7x/wk	3-5x/wk	1-3x/wk	None	Type
Exercise	☐	☐	☐	☐	☐Aerobic ☐Weights

	8+ hrs	7-8 hrs	6-7 hrs	5-6 hrs	<5 hrs
Sleep	☐	☐	☐	☐	☐

	5+	4	3	2
Meals / day	☐	☐	☐	☐

	64+ oz	32-64 oz	16-32 oz	<8 oz
Water / day	☐	☐	☐	☐

WORK ACTIVITY: ☐ Heavy Labor ☐ Light Labor ☐ Mostly Sitting ☐ Mostly Standing ☐ Walking / Moving ☐ Driving

FAMILY HISTORY: Identify any conditions that you, or any of your family members have now or have had in the past:
(**F** = Family, **P** = Personal History)

___Alcoholism
___Anemia
___Cancer
___Cold sores
___Deep vein thrombosis
___Detached retina
___Diabetes
___Eczema
___Emphysema
___Epilepsy
___Goiter
___Gout
___Heart disease
___HIV / AIDS
___Miscarriage(s)
___Mumps
___Pleurisy
___Pneumonia
___Polio
___Rheumatic fever
___Stroke
___Tumor(s)
___Ulcer(s)
___Other: _____
_____
_____

_____ _____ _____

Patient's Printed Name Patient's Signature Date

Reviewed By: _____ Date: _____