LEDFORD CHIROPRACTIC, P.C.
CALHOUN, GA 30701
706-602-9696

NEW PATIENT INTRODUCTION TO OFFICE

Patient Name: ______________________________ Date: ______________________

Medical Doctor: ______________________________ Office Name: ______________________

Patient Sex: ___M ___ F Patient Age: _____ Date of Birth: ____________________ SS#______________________

Patient Address: ______________________________ City ____________________ State_______ Zip ___________

Home Phone: ____________________ Work Phone: ____________________ email address______________________

Employer: ______________________________ Occupation: ______________________________

Insurance Co.: ______________________________ Person Insured: ______________________________

Subscriber employer: ______________________________ Relationship: ______________________________

Who may we thank for referring you? ______________________________

Emergency Contact: ______________________________ Phone Number: ______________________________

COMPLAINT HISTORY

1. Describe your current complaint in the best detail as possible. ______________________________
____.
2. How long have you had this condition? ______________________ Date of onset: ______________________
3. Are you aware of what caused the injury or condition, if so what? ______________________________
4. How would you describe the pain? ___ Sharp ___ soreness ___ throbbing ___ tingling ___ dull ___ stiffness ___ spasm
___ Burning ___ ache ___ weakness ___ numbness ___ shooting ___ constant ___ comes and goes ___ extreme (check all that apply)
5. How would you rate the intensity of your pain? (Circle the most appropriate number)

0 1 2 3 4 5 6 7 8 9 10

(No pain) (Moderate pain) (Terrible/ unbearable pain)

6. How often is the pain present?

___ Constant (81-100%) ___ frequent (51-80%) ___ occasional (26-50%) ___intermittent (25% or less of the time)

7.Since your problem began is the pain:

___ Getting worse ___ getting better ___staying the same

8. How did your problem begin? ___ Auto accident ___ work accident ___ gradual onset ___ sudden onset ___ no specific reason

___Other accident or injury—Explain______________________________

9. What makes your problem better? ______________________________

10. What makes your problem worse? ______________________________

11. Are your currently taking any medications? If yes please describe. ______________________________

12. Have you been previously treated for this condition, if yes by whom and the results? ______________________
____.

13. What is your physical activity at work? ___ Mostly sitting ___ light labor ___ moderate labor ___ heavy labor

Please describe: ______________________________

SOCIAL HISTORY

1. Do you smoke? ___ Yes ___ no, If so how much per day? ________________

2. Do you drink alcohol? ___ Yes ___ no, If so how much per day, per week? ____

3. Do you have any history of cancer or tumors? If so please describe in detail. ____

____

4. How is your sleep? ___ Poor ____ average ___ excessive

5. Does your pain ever wake your from sleeping? ___ Yes ___ no, if so how often? ____

6. When is your pain the worst? ____ Morning (rising from sleep) ___ mid –day ___ evening ___ night (while in bed)

WOMEN ONLY: MENSTRUAL HISTORY

1. Date of onset of last period ___________________. Age of onset of menstrual cycles ____ Are they regular ___ yes ___no

If not explain. ____

2. Are you currently pregnant? ___ Yes ___no are your currently using birth control? ___Yes ___no what? ______________________

FAMILY HEALTH HISTORY

	SELF	FATHER	MOTHER	BROTHER (S)	SISTER (S)	SPOUSE	CHILDREN
ARTHRITIS							
ASTHMA							
BACK PAIN							
BURSITIS							
CANCER							
DIABETES							
Disc Problem							
EMPHYSEMA							
EPILEPSY							
HEADACHES							
Heart trouble							
High blood pres							
INSOMNIA							
KIDNEY DX							
MIGRAINES							
NERVOUSNESS							
SCOLIOSIS							
Sinus Trouble							
Stomach Trouble							
Other							

I certify that all information given is accurate to the best of my knowledge. I understand all questions asked and the answers given; I understand that given incorrect information can be dangerous to my health. I authorize the chiropractor to perform any test or procedures necessary to determine the care I may need. I also authorize the chiropractor to treat me with usual and customary means to his technique. I also understand I am responsible for all bills incurred due to my care, regardless of any arrangement with my insurance company.

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Signature of Patient (or parent of a minor) Date