NEW PATIENT APPLICATION

Welcome to Pascal Chiropractic! We are so glad that you have taken the first steps in living a healthier life. Our mission is to help you achieve your health goals by optimizing your body's function and removing interferences to the body's nervous system.

Name: ____ Date: ___/___/_____

Address____

City: _________________ State: ________ Zip Code: ____________

Home Phone: (_____) _______________ Cell Phone: (_____) _______________

Birth Date: ___/___/______ Age: _____ Marital Status: S M D W

Spouse's Name: _____________________________ Number of Children: ___________

Children's Name(s) and ages: ____

Email: ____

Who referred you to our office or how did you hear about us? __________________________

Have you ever seen a chiropractor prior? Yes No If yes, when and for what problem? How was your experience? ____

____

HEALTH HISTORY

Describe the major concern you wish to discuss: ___________________________________

____

When and how did this problem begin? ____

____

If you have pain, how does it feel? (sharp, dull, aching, throbbing, stabbing, etc?) __________

____

How often does this bother you? ____

Does your pain travel? Yes No If yes, where? ___________________________

What increases your symptoms (activities, time of day, position, etc)? __________________

____

What decreases your symptoms (activities, time of day, position, rest, medication, etc)?

____

Are your symptoms constant or do they come and go? ______________________________

What have you tried to do to solve your problem that have not worked? _________________

____

How does this problem affect your family life? ______________________________________

____

How does this problem affect your work? ____

____

How does this problem affect your social life, sports, and hobbies? _____________________

____

When it is at it's worst, how much older (than you are) does this problem make you feel? Why?

____

Have you become discouraged about getting this problem handled? _____________________

On a scale of 1-10 (1 being not committed, 10 being fully committed) rate your commitment to breaking free of this issue. __________________

On a scale of 1-10 (1 being not committed, 10 being fully committed) how committed are you to optimizing your health and wellness? ____________________

Have you seen any other health professionals for this problem? If so, who, when, and what were the results?

____

Have you seen any other health professional for any other problem in the last year? If yes, why?

____

INITIAL _____

List all surgical operations/ hospital stays you've had and years:

____

____

List any past traumas/ injuries you have had in your life (car accidents, falls, work injuries, etc):

____

____

____

List all over the counter and/ or prescription medications you take and what are they for?

____

____

What supplements to you take and what are for? ____

____

List your major stressors: ____

____

____

What is your occupation? ____

Most of the day is spent SEATED, STANDING, or MOVING? Please elaborate: _______________________

____

If you work at a desk, is it adjustable (standing, ergonomic)? _______________________________________

SOCIAL HISTORY I DO YOU…

Smoke? Yes No ____packs a day, for _____ years

Drink? Yes No How often/ how much? __________________

Exercise? Yes No How often/for how long? _________________

How would you rate your diet? Excellent Good Fair Poor

How would you classify your body? Too heavy Average Too light

Are you currently on a weight loss program? Yes No

Are you currently on a special diet? Yes No If yes, why?

____

INITIAL _____

What does a typical day of meals consist of?

Breakfast: ____

____

Lunch: ____

____

Snacks: ____

____

Dinner: ____

____

CHECK ALL PROBLEMS YOU HAVE EXPERIENCED:

DIZZINESS/VERTIGO	MID BACK PAIN	LOW BACK PAIN
HEADACHES	ALLERGIES	NUMBNESS IN ARMS
NECK PAIN	EAR INFECTIONS	NUMBNESS IN HANDS
VISION CHANGES	CHEST PAIN	NUMBNESS IN LEGS
NAUSEA	SINUS ISSUES	THYROID PROBLEMS
HEART PROBLEMS	ANXIETY	RINGING IN EARS
DEPRESSION	LACK OF/POOR SLEEP	FERTILITY ISSUES
NERVOUSNESS	SHOULDER PAIN	KIDNEY ISSUES
EPILEPSY/SEIZURES	TMJ/JAW PAIN	ARM PAIN
CHRONIC FATIGUE	INSOMNIA	DIGESTIVE ISSUES
ECZEMA/RASH	ACID REFLUX/ULCERS	HIGH/LOW BLOOD PRESSURE
HEARING LOSS	LIBIDO PROBLEMS	STOMACH ISSUES
ARTHRITIS	GALLBLADDER PROBLEMS	CONCENTRATION ISSUES
AUTISM SPECTRUM	CONSTIPATION/DIARRHEA	MENSTRUAL PROBLEMS
LUNG ISSUES (COPD)	BLADDER PROBLEMS	NUMBNESS IN FEET
LIVER DISEASE	SHORTNESS OF BREATH	ASTHMA

INITIAL _____

FAMILY HISTORY

CONDITION	MOTHER	FATHER	SIBLINGS	CHILDREN	SPOUSE
Anxiety/Depression					
Arthritis					
Asthma/Allergies/Sinus Issues					
Bed Wetting					
Cancer					
Deceased (cause?)					
Diabetes					
Digestive issues/Heartburn					
High or Low Blood Pressure					
Ear Infections					
Fibromyalgia					
Fertility Problems					
Headaches/Migraines					
Neck/ Back Pain/ Disc Issues					
Menstrual Problems					
Scoliosis					
TMJ Dysfunction					

Do any of your friends or relatives see a chiropractor? YES NO

What would you like to gain in our office? ____

____

INITIAL _____

Drs. Pascal does not treat medical conditions. Their care is designed to help remove the barriers to normal body functions and help restore your body's own ability to be healthy and symptom free. If Drs. Pascal finds that they will be able to help you would you want to receive care?   YES   NO

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (RELIEF CARE). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (CORRECTIVE CARE). Drs. Pascal will consider your needs and desires when recommending your treatment program.

Please check the type of care that you are considering:

_____Relief Care   _____ Corrective Care   _____ I want Drs. Pascal to select the best type of care for my problem.

I hereby authorize Drs. Pascal to examine me as they deem appropriate. I understand that the examination may exacerbate my condition. I understand that I am responsible for all of the bills that I incur at this office. Drs. Pascal will not be held responsible for any pre-existing medically diagnosed conditions, disease or for any medical diagnosis.

Patient Signature _______________________________________ Date __________________

Consent to Treat a Minor ____ Date __________________

INITIAL _____