Pentz Family Chiropractic Life Center, LLC
New Patient Information Form

Please fill out all information completely

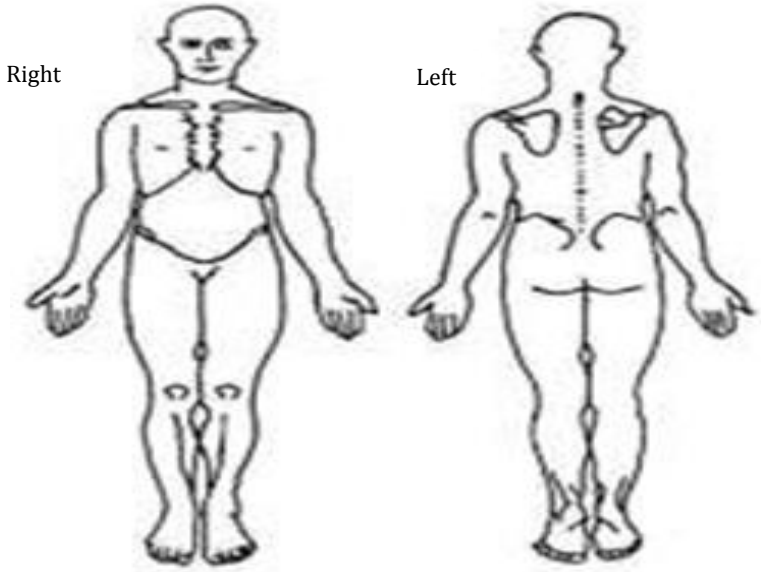
Name:_____ Nickname:_____
Address: _____
City, State, Zip Code:_____
Date of Birth: ____/____/_____ Phone: ( ) _____ O Home O Cell O Work
E-mail: _____ Sex: O Male O Female
Occupation: _____ Employer: _____
Marital Status: O Single O Married O Divorced O Widowed Spouse's Name: _____
Do you have children? O Yes O No Names and Ages:_____
Whom may we thank for referring you to our practice? _____
Have you been to a Chiropractor in the past? O Yes O No Last adjustment: _____
Would you like appointment reminders? O via Text (Cell Provider: _____) OR O via Email
Choose: O Same Day OR O Day Before

Present Complaint? What is the reason for your visit today?

_____

Pain/Problem started on: _____ The pain is: O Constant O Comes and Goes
Pains are: O Dull O Achy O Shooting O Sharp O Burning O Numb O Tingling

******Please mark the location of your pain******



What aggravates your pain? (sitting, standing, working, etc.): _____
_____
What lessens your pain? (ice, heat, rest, stretching, etc.): _____
_____
Is the condition/pain worse at certain times of the day? _____
How does this pain affect your daily routine? _____
Other practitioners seen for this condition: _____
What has your pain/problem cost you? (financially, work, social, family, etc.): _____
_____

Do you ever experience any of the following:

O Neck pain/stiff	O Feet cold	O Fatigue	O Allergies
O Upper back pain	O Hands cold	O Dizziness/Fainting	O Asthma
O Mid back pain	O Headache/Migraine	O Shortness of Breath	O Nausea
O Low back pain	O Ears ring/buzz	O Abnormal BP	O Diarrhea
O Leg pain	O Earache/infection	O Loss of Memory	O Constipation
O Arm pain	O Tension/Stress	O Loss of Smell	O Hemorrhoids
O Numbness in Fingers	O Sleeping problems	O Loss of Taste	O Digestive issues
O Numbness in Toes	O Scoliosis	O Chest pains	O Menstrual cramps
O Pins and Needles in Legs	O Fever	O Seizures	O Other: _____
O Pins and Needles in Arms	O Jaw pain	O Depression/Anxiety	_____

Health History ***Check all that apply; include description and date if indicated***

YOUR Birthing History

O Long Delivery O Difficult Delivery O Forceps O C-Section O Breach O Induced Labor

Childhood and Development

O Breastfed O Fall out of bed O Bang your head O Childhood sickness O Childhood accidents
O Fall down the stairs O Pulled by your arm O Childhood surgery

Adulthood and Current Habits: O Exercise O Smoke O Alcohol O Diet O Physical/mental stress

*Please complete the following section **regardless** if you feel it is related to your complaint today*

O Auto accidents (major or minor): _____
O Work injuries: _____
O Sports injuries: _____
O Broken bones: _____
O Slips/Falls: _____
O Surgery: _____
O Medications: _____

Family History *(Parents, Siblings or Grandparents)*

O Heart Disease O Arthritis O Cancer O Diabetes O Multiple Sclerosis O Other: _____

As a result of my Chiropractic care, I would like to:

O Feel better quickly O Live a healthier lifestyle O Have a healthier spine

I would like to consult with the doctor regarding:

O Help losing weight O Help with a drug addiction O Help to quit smoking

_____ _____
Signature Date