Legacy CLINIC OF CHIROPRACTIC

New Patient Information

Name_____ **Date**_____

Address_____

City_____

State_____ **Zip**_____

E-Mail_____ **Occupation**_____

Referred By_____ **Date of Birth**_____

Home Phone _____ **Cellular Phone**_____

Age:	**Wt:**	**Ht:**	**BP:**

Family History (check all that apply):

Stroke_____
High BP_____
Depression_____
Heart Disease_____
Arthritis _____
Cancer___ Type?_____
Diabetes_____
Weight Problems_____
Ulcer_____
Psoriasis_____
Glaucoma_____

Personal History (circle all that apply):

Arthritis Stroke High Cholesterol How High?_____ High Blood Pressure How High?_____ Diabetes Metabolic Syndrome Insulin Resistance Low Blood Sugar Chronic Fatigue Fibromyalgia Multiple Chemical Sensitivities Infectious Mononucleosis Frequent Colds/Flu Herpes/ HPV Cold Sores Cancer What type?_____ Thyroid Problems Hypothyroidism Hyperthyroidism	Headaches Chronic Tension Migraines Cluster Hormonal Food Allergies To What?_____ Seasonal Allergies To What?_____ Medication Allergies To What?_____ Sleep Problems Forgetfulness Hot Flashes PMS Birth Control Pills/ Hormones Weight Problems Constipation Diarrhea Abdominal Cramping/ Bloating Yeast Infections Low Libido Ulcers

What Medications and Dosages are you currently taking? List all please:

_____

_____

_____

What Vitamins and herbal supplements are you taking? List all please:

_____

_____

Do you eat, drink, or use (circle all that apply):

Antacids	Protein Drinks	Appetite Suppressants
Aspirin	Alcohol	Coffee
Tylenol	Tap Water	Decaf Coffee
Ibuprofen	Bottled Water	Diet Soda
Laxatives	Tea	Soda
Refined Sugars	Candy	White Bread
Margarine	Butter	Fast Foods
Chewing Gum	Fried Foods	Chips
Salt (w/out tasting)	Tobacco	Cigarettes
Artificial Sweeteners (Blue, Pink, Yellow)		Coffee Creamers

List any food aversions and/or foods you dislike:

_____

Do you get noticeably irritated, weak, or lightheaded if you haven't eaten in a while?

_____

Do you crave certain foods? _____ What foods? Sweets? Chocolate?
Bread/Pasta? Fried Foods? Alcoholic drinks? Sodas/Diet Sodas? Meat?
Other? _____

Are you:
Under excessive amounts of stress_____ at home_____ at work_____
Physical Stress_____ Mental Stress_____
Exposed to chemicals regularly_____ Type_____
Exposed to smoke regularly_____

How often do you have bowel movements? _____per day/ week/ month
Urinate? _____ per day

How is your dental health? Prone to Cavities? Gum Disease? Bleeding Gums?

_____

Are your nails week or brittle?_____

Average Sleep per night? _____

Any sleeping problems? _____

To what extent will you commit to achieving better health?
Little_____ Moderate _____ Major_____ Extreme_____

Is there anything else about either your history or your current condition that you feel is important to mention?

_____

_____