SCOTT S. SARDONICUS, DC

215 BROWNS RIDGE RD; OSSIPEE NH 03864

Today's Date: _____

CHIROPRACTIC NEW PATIENT HISTORY

Name: _____ Birth Date: _____ Sex: _____

Mailing Address: _____

Home Phone: _____ Work Phone: _____ How did you hear about us? _____

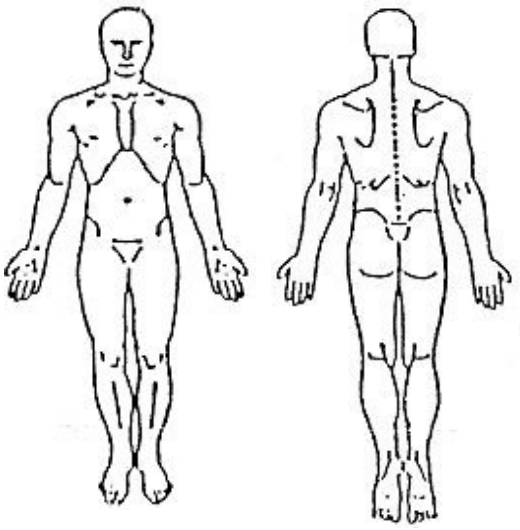
Cell Phone: _____ e-mail: _____ left-handed or right-handed (circle one)

REASON FOR VISIT

Are you here for: ☐ a wellness checkup ☐ a specific concern

Current health concern(s) – please include *frequency*, *duration* and *severity (scale of 1-10 where 10 is worst)*: _____

Please indicate, in red, areas of pain or discomfort.



Relating to your health concern, WHEN and HOW did it begin? _____

Are there times, activities, and/or treatments that make it BETTER? _____

WORSE? _____

Other treatments tried and effects: _____

Are you currently seeing another Health Care Provider? ☐ Y ☐ N If yes, give name, address and phone number and for what reason you are being treated: _____

List any medications, supplements, or medicinal herbs? _____

Other concerns and/or goals? _____

How would you rate your level of stress: NONE 1 2 3 4 5 6 7 8 9 10 HIGH

How would you rate your level of overall vitality: 0% ---------- 100%

PAST HISTORY

PLEASE NOTE DATE OR AGE AND WHAT WAS INJURED.

Accidents/Falls/Injuries: _____

_____

_____

Auto Accidents: _____

_____

Severe Illness: _____

Surgeries: _____

Hospitalizations for any other reason: _____

Date of last X-ray: _____ Area(s) X-rayed: _____ Reason, if not already listed: _____

History of high impact or contact sports: _____

_____

HAVE YOU EVER BEEN UNDER CHIROPRACTIC CARE? ☐ Y ☐ N About how many adjustments have you received? _____

Date of last visit to a chiropractor: _____ Condition treated: _____

Were you satisfied? _____

Why did you discontinue or want to change chiropractors? _____

Previous chiropractor's name, address & phone #: _____

DIET & LIFESTYLE

How many glasses of water do you drink per day? _____ Do you have good eating habits? ☐ Y ☐ N _____

_____

_____

_____

Do you do any daily or regular activity for your health and well being or for stress management? ☐ Y ☐ N If yes, what do you do and how often? _____

SLEEP: Ave. # of hours/night ___ Is it enough? _____ POSTURE: Side Back Stomach Use Cervical Pillow: 0 1 2

OCCUPATION: _____ EMPLOYER'S NAME & ADDRESS: _____

_____

Does your work involve prolonged sitting?	☐ Y	☐ N	At a computer?	☐ Y	☐ N
Heavy lifting?	☐ Y	☐ N	Exposure to toxic chemicals?	☐ Y	☐ N
Mental pressure or worry?	☐ Y	☐ N	Repetitive motions?	☐ Y	☐ N

Household: Please list names and ages: _____

Is there anything else that might have a bearing on your health? _____

_____

Are there any family health challenges that may affect your health? _____

_____

_____

_____

Please draw clock hands to display the time 3.5 hours earlier than the time shown on the following image:

Current health goals: _____

_____

_____

Please indicate below why you are choosing chiropractic care.

1. For the relief of my pain or symptoms only.
2. Relief of pain and symptoms and regular chiropractic care for my continued good health.
3. I would like the doctor to decide the most appropriate care for me.

_____

Signature Date

Authorization for Care of Minor:

I hereby authorize this clinic and its doctor(s) to administer care as they deem necessary to my son/daughter/ward

_____

Signed Witness Date