Stark Family Chiropractic Inc.
New Patient Information Form

Please print clearly:

Name _____ Date _____

Address _____ Apt.# _____

City _____ State _____ ZIP _____

Home Phone (____) ____-_____ Work Phone (____) ____-_____

Cell Phone (____) ____-_____ Email Address _____

REFERRED BY: _____

Occupation _____ Employer _____

Date of Birth _____ Age ____ Sex: M/F Height _____ Weight _____

Overall health (circle one): Excellent / Good / Fair / Poor / Other: _____

Chief complaint (reason you are here): (use separate sheet if more room needed)

_____

Previous treatments for this complaint _____

_____

Other complaints or problems: (use separate sheet if needed) _____

_____

Current medications/drugs being taken: (use separate sheet if needed) _____

_____

Are you currently under the care of a physician or other health care professionals?
(If yes, please give name and date of last visit):

_____

Nutritional supplements you are taking: _____

Do you smoke, drink coffee or alcohol? (if yes indicate how much)

Cigarettes _____ Coffee _____ Alcohol _____

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Office Use Only:

Stark Family Chiropractic Inc.
New Patient Information Form

Name: _____ Date _____

HISTORY:

List any major illnesses (with approx. dates): _____

_____

List any surgery or operations with approx. date: _____

_____

Past Accidents or injuries: _____

_____

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Marital Status: S M D W Name of Spouse _____

Describe health of spouse: _____ Number of children if any ____

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	____	M/F	_____
_____	____	M/F	_____
_____	____	M/F	_____

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other _____

Any household pets or other animals you or family members are in close contact with:

_____

SIGNED: _____ DATE _____

SYMPTOM SURVEY FORM

NAME _____ **DOCTOR** _____ **DATE** _____

AGE _____ **SEX M**___ **F** ___

Phone # (_____) _____

INSTRUCTIONS: Number the boxes which apply to you with either a 1, 2, or 3
(1) for **MILD** symptoms ***(1-2x in past 6 months)***
(2) for **MODERATE** symptoms ***(1-2x in past month)***
(3) for **SEVERE** symptoms ***(1-2x in past week)***
Leave the box **BLANK** if it does not apply to you!

GROUP 1

1 ☐ Acid foods upset
2 ☐ Get chilled, often
3 ☐ "Lump" in throat
4 ☐ Dry mouth-eyes-nose
5 ☐ Pulse speeds after meals
6 ☐ Keyed up - fail to calm
7 ☐ Cuts heal slowly
8 ☐ Gag easily
9 ☐ Unable to relax; startles easily
10 ☐ Extremities cold, clammy
11 ☐ Strong light irritates
12 ☐ Urine amount reduced
13 ☐ Heart pounds after retiring
14 ☐ "Nervous" stomach
15 ☐ Appetite reduced
16 ☐ Cold sweats often
17 ☐ Fever easily raised
18 ☐ Neuralgia-like pains
19 ☐ Staring, blinks little
20 ☐ Sour stomach frequent

GROUP 2

21 ☐ Joint stiffness after arising
22 ☐ Muscle-leg-toe cramps at night
23 ☐ "Butterfly" stomach, cramps
24 ☐ Eyes or nose watery
25 ☐ Eyes blink often
26 ☐ Eyelids swollen, puffy
27 ☐ Indigestion soon after meals
28 ☐ Always seems hungry; feel "lightheaded" often
29 ☐ Digestion rapid
30 ☐ Vomiting frequent
31 ☐ Hoarseness frequent
32 ☐ Breathing irregular
33 ☐ Pulse slow; feels "irregular"
34 ☐ Gagging reflex slow
35 ☐ Difficulty swallowing
36 ☐ Constipation, diarrhea alternating
37 ☐ "Slow starter"
38 ☐ Get "chilled" infrequently
39 ☐ Perspire easily
40 ☐ Circulation poor, sensitive to cold
41 ☐ Subject to colds, asthma, bronchitis

GROUP 3

42 ☐ Eat when nervous
43 ☐ Excessive appetite
44 ☐ Hungry between meals
45 ☐ Irritable before meals
46 ☐ Get "shaky" if hungry
47 ☐ Fatigue, eating relieves
48 ☐ "Lightheaded" if meals delayed
49 ☐ Heart palpitates if meals missed or delayed
50 ☐ Afternoon headaches
51 ☐ Overeating sweets upsets
52 ☐ Awaken after few hours sleeps – hard to get back to sleep
53 ☐ Crave candy or coffee in afternoons
54 ☐ Moods of depression – "blues" or melancholy
55 ☐ Abnormal craving for sweets or snacks

GROUP 4

56 ☐ Hands and feet go to sleep easily, numbness
57 ☐ Sigh frequently, "air hunger"
58 ☐ Aware of "breathing heavily"
59 ☐ High altitude discomfort
60 ☐ Opens windows in closed room
61 ☐ Susceptive to colds and fevers
62 ☐ Afternoon "yawner"
63 ☐ Get "drowsy" often
64 ☐ Swollen ankles worse at night
65 ☐ Muscle cramps, worse during exercise; get "charley horses"
66 ☐ Shortness of breath on exertion
67 ☐ Dull pain in chest or radiating into left arm, worse on exertion
68 ☐ Bruise easily, "black/blue" spots
69 ☐ Tendency to anemia
70 ☐ "Nose bleeds" frequent
71 ☐ Noises in head or "ringing in ears"
72 ☐ Tension under the breastbone, or feeling of "tightness", worse on exertion

GROUP 5

73 ☐ Dizziness
74 ☐ Dry Skin
75 ☐ Burning feet
76 ☐ Blurred vision
77 ☐ Itching skin and feet
78 ☐ Excessive falling hair
79 ☐ Frequent skin rashes
80 ☐ Bitter, metallic taste in mouth in mornings
81 ☐ Bowel movement painful or difficult
82 ☐ Worries, feels insecure
83 ☐ Feeling queasy; headache over eyes
84 ☐ Greasy foods upset
85 ☐ Stools light-colored
86 ☐ Skin peels on foot soles
87 ☐ Pain between shoulder blades
88 ☐ Use laxatives
89 ☐ Stools alternate from soft to watery
90 ☐ History of gallbladder attacks or gallstones
91 ☐ Sneezing attacks
92 ☐ Dreaming, nightmare type bad dreams
93 ☐ Bad breath (halitosis)
94 ☐ Milk products cause distress
95 ☐ Sensitive to hot weather
96 ☐ Burning or itching anus
97 ☐ Crave sweets

GROUP 6

98 ☐ Loss of taste for meat
99 ☐ Lower bowel gas several hours after eating
100 ☐ Burning stomach sensations, eating relieves
101 ☐ Coated tongue
102 ☐ Pass large amounts of foul-smelling gas
103 ☐ Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
104 ☐ Mucus colitis or "irritable bowel"
105 ☐ Gas shortly after eating
106 ☐ Stomach "bloating" after eating

GROUP 7

(A)

107 ☐ Insomnia
108 ☐ Nervousness
109 ☐ Can't gain weight
110 ☐ Intolerance to heat
111 ☐ Highly emotional
112 ☐ Flush easily
113 ☐ Night sweats
114 ☐ Thin, moist skin
115 ☐ Inward trembling
116 ☐ Heart palpitates
117 ☐ Increased appetite without weight gain
118 ☐ Pulse fast at rest
119 ☐ Eyelids and face twitch
120 ☐ Irritable and restless
121 ☐ Can't work under pressure

(B)

122 ☐ Increase in weight
123 ☐ Decrease in appetite
124 ☐ Fatigue easily
125 ☐ Ringing in ears
126 ☐ Sleepy during day
127 ☐ Sensitive to cold
128 ☐ Dry or scaly skin
129 ☐ Constipation
130 ☐ Mental sluggishness
131 ☐ Hair coarse, falls out
132 ☐ Headaches upon arising wear off during day
133 ☐ Slow pulse, below 65
134 ☐ Frequency of urination
135 ☐ Impaired hearing
136 ☐ Reduced initiative

GROUP 7 (continued)

(C)

137 ☐ Failing memory
138 ☐ Low blood pressure
139 ☐ Increased sex drive
140 ☐ Headaches, "splitting or rending" type
141 ☐ Decreased sugar tolerance

(D)

142 ☐ Abnormal thirst
143 ☐ Bloating of abdomen
144 ☐ Weight gain around hips or waist
145 ☐ Sex drive reduced or lacking
146 ☐ Tendency to ulcers, colitis
147 ☐ Increased sugar tolerance
148 ☐ Women: menstrual disorders
149 ☐ Young girls: lack of menstrual function

(E)

150 ☐ Dizziness
151 ☐ Headaches
152 ☐ Hot flashes
153 ☐ Increased blood pressure
154 ☐ Hair growth on face or body (female)
155 ☐ Sugar in urine (not diabetes)
156 ☐ Masculine tendencies (female)

(F)

157 ☐ Weakness, dizziness
158 ☐ Chronic fatigue
159 ☐ Low blood pressure
160 ☐ Nails weak, ridged
161 ☐ Tendency to hives
162 ☐ Arthritic tendencies
163 ☐ Perspiration increase
164 ☐ Bowel disorders
165 ☐ Poor circulation
166 ☐ Swollen ankles
167 ☐ Crave salt
168 ☐ Brown spots or bronzing of skin
169 ☐ Allergies - tendency to asthma
170 ☐ Weakness after colds, influenza
171 ☐ Exhaustion - muscular and nervous
172 ☐ Respiratory disorders

FEMALE ONLY

173 ☐ Very easily fatigued
174 ☐ Premenstrual tension
175 ☐ Painful menses
176 ☐ Depressed feeling before menstruation
177 ☐ Menstruation excessive and prolonged
178 ☐ Painful breasts
179 ☐ Menstruate too frequently
180 ☐ Vaginal discharge
181 ☐ Hysterectomy/ovaries removed
182 ☐ Menopausal hot flashes
183 ☐ Menses scanty or missed
184 ☐ Acne, worse at menses
185 ☐ Depression of long standing

MALES ONLY

186 ☐ Prostate trouble
187 ☐ Urination difficult or dribbling
188 ☐ Night urination frequent
189 ☐ Depression
190 ☐ Pain on inside of legs or heels
191 ☐ Feeling of incomplete bowel evacuation
192 ☐ Lack of energy
193 ☐ Migrating aches and pains
194 ☐ Tire too easily
195 ☐ Avoid activity
196 ☐ Leg nervousness at night
197 ☐ Diminished sex drive

IMPORTANT

TO THE PATIENT: Please list below the five main health complaints you have in order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____

SUBSTANCE SURVEY FORM

Name _____ **Date** _____

Please list any prescription medications you are taking or have taken in the last year:

Product	Symptom	Quantity & Frequency

Please list any over-the-counter medications you are currently taking or have taken in the last year:

Product	Symptom	Quantity & Frequency

Please list any vitamins, supplements, herbs, or homeopathic medicines you are currently taking or have taken in the last year: (Use other side if needed.)

Product	Symptom	Quantity & Frequency

Check the following items which apply to you and indicate the amount used:

☐ Coffee	_____	☐ Artificial Sweeteners	_____	☐ Ice Cream	_____
☐ Tea	_____	☐ Antacids	_____	☐ Alcohol	_____
☐ Soft Drinks	_____	☐ Laxatives	_____	☐ Cigarettes	_____
☐ Diet Soft Drinks	_____	☐ Candy	_____	☐ Other Tobacco Products	_____

Stark Family Chiropractic Inc.

Notice of Privacy Practices

This notice describes how your information is stored, may be used, and/or disclosed.

How we store your information: Patient information is stored here in the office on a secure server with no outside access. Patient charts and x-ray films are also stored here in the office. Patient charts/x-ray films do not leave the premises unless one of the doctors needs to review notes about your case after hours. In this instance, the patient chart is solely in the doctor's possession until the following morning when said chart is returned to the office.

What we do not do with your information: Information that you have provided to us about your financial situation, medical conditions, and care you have received is held in the strictest of confidence. This applies whether information was communicated during a discussion, in writing, via email, over the phone (including information left on voice mails), or text.

We do not give out, exchange, barter, rent, sell, or disseminate any information about our patients to anyone who receives our services. Know that any and all patient information is confidential and is held in a HIPAA compliant manner.

How we do use your information: Information is only used as is reasonably necessary to process your care, send billing to an insurance company, or to provide you with health care services which may require communication between Stark Family Chiropractic Inc. and other health care providers.

No patient's information or identifying photos will ever be used without patient's advanced written permission.

Printed Name:_____

Signature:_____

Date:_____