NEW PATIENT APPLICATION

Welcome to Reyes Active Body Chiropractic! Please thoroughly complete all questions. Thank you.

Name: _____ Today's Date: _____

Address: _____

City/State/Zip: _____ E-Mail: _____

Phone: Home _____ Work: _____ Cell: _____

Birth date: ____/____/____ Age: _____ Referred by: _____

Marital status: M/W/D/S Spouse name: _____ Children: Y/N

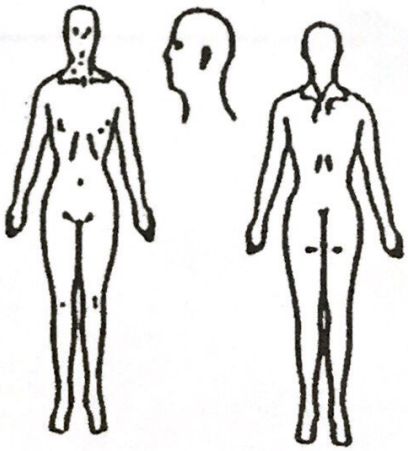
Your previous doctor of chiropractic: _____

Your Occupation: _____ Employer: _____

Favorite hobbies or interests: _____

_____

Mark area(s) of Health Concerns



Health reasons for consulting our office:

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

Have you had same or similar problem(s) before? Y/N

Father/Mother/Brother/Sister/Children with similar problems?

_____

Other doctors you have consulted for this problem: _____

ANY Surgery you have had (type and date):

_____

_____

ANY major accidents/traumas: _____

Current medications: _____

Current Supplements: _____

Are you under emotional stress: Y/N
Do you have enough energy for daily activities? Y/N
Are you getting 7-8 hours of restful sleep per night? Y/N

What have you heard about chiropractic care?

_____

Do you know what a subluxation is? If yes, please describe

_____

What daily health habits do you practice?

_____

HIPAA release document available upon request from Front Desk Receptionist.

The above information is true and accurate to the best of my knowledge. My reason for consultation with the doctor is for evaluation of my physical health and the potential for improvement.

_____

Patient or Guardian Signature: _____ ***Date:***
_____/_____/_____

Broken Bones _____ _____

Dislocations _____ _____

Surgeries _____ _____

Review of Systems - Have you ever had any of the following?

Cardiovascular
☐ No to all

☐ Poor Circulation
☐ High Blood Pressure
☐ Aortic Aneurysm
☐ Heart Disease
☐ Vascular Disease
☐ Heart Attack
☐ Chest Pain
☐ High Cholesterol
☐ Pace Maker

Respiratory
☐ No to all

☐ Asthma
☐ Tuberculosis
☐ Shortness of Breath
☐ Emphysema
☐ Bronchitis
☐ Pneumonia
☐ Cold/Flu
☐ Cough/Wheezing
☐ Sputum
☐ Coughing Blood

Musculoskeletal
☐ No to all

☐ Gout
☐ Arthritis
☐ Rheumatoid Arthritis
☐ Joint Stiffness
☐ Muscle Weakness
☐ Osteoporosis
☐ Fractures
☐ Joint Replacement
☐ Disc Herniation
☐ Hernia

Allergic/Immunologic
☐ No to all

☐ Hives
☐ Immune Disorder
☐ HIV/AIDS
☐ Allergy Shots
☐ Cortisone Use

Neurological
☐ No to all

☐ Stroke
☐ Seizures
☐ Parkinson's Disease
☐ Multiple Sclerosis
☐ Brain Aneurysm
☐ Numbness
☐ Pinched Nerves
☐ Carpal Tunnel
☐ Balance Problems

Head
☐ No to all

☐ Headaches
☐ Severe Headaches
☐ Migraines
☐ Head Injury

Skin
☐ No to all

☐ Skin Lesions
☐ Skin Ulcers
☐ Skin Disease/Cancer
☐ Eczema
☐ Psoriasis

Gastrointestinal
☐ No to all

☐ Gallbladder Problems
☐ Bowel Problems
☐ Constipation
☐ Liver Problems/Disease
☐ Ulcers
☐ Diarrhea
☐ Nausea/Vomiting
☐ Bloody Stools

Genitounrinary
☐ No to all

☐ Kidney Disease
☐ Lower Side Pain
☐ Burning Urination
☐ Frequent Urination
☐ Blood in Urine
☐ Kidney Stones

Hematologic/Lymphatic
☐ No to all

☐ Hepatitis
☐ Blood Clots
☐ Cancer
☐ Easy Bruising
☐ Easy Bleeding
☐ Fevers/Chills/Sweats

Endocrine
☐ No to all

☐ Thyroid Disease
☐ Diabetes
☐ Hair Loss
☐ Menopausal
☐ Menstrual Problems

Psychiatric
☐ No to all

☐ Depression
☐ Anxiety Disorder
☐ Eating Disorder
☐ Unusual Stress

Ears/Nose/Throat
☐ No to all

☐ Hearing Loss
☐ Sinus Infection
☐ Nosebleed
☐ Sore Throat
☐ Difficulty Swallowing
☐ Bleeding Gums

Eyes
☐ No to all

☐ Glaucoma
☐ Double Vision
☐ Blurred Vision

General
☐ No to all

☐ Weight Loss
☐ Weight Gain
☐ Energy Level Problem
☐ Anemia
☐ Difficulty Sleeping

I acknowledge that all information and answers given on this form are accurate to the best of my knowledge and understand that it is my responsibility to inform the office of any changes in my health or health condition.

Patient signature: _____ Date: _____