Norris Chiropractic
Health & Wellness Clinic
1205 Vermont Street
Quincy, Illinois 62301
(217) 224-6900

NEW PATIENT INFORMATION

PLEASE PRINT CLEARLY

Full Name: ____________________ E-mail ____________________ Gender: ☐M ☐F Age: ____ Birth Date: __________

Address: ______________________________ City: ________________ State: __________ Zip: ______________

Social Security #: ____________________ Driver's License #: ____________________ Home Phone: (___)__________

Marital Status: ☐S ☐M ☐D ☐W # of Children: ____ Work Status: ☐Full-time ☐Part-time ☐Retired Cell Phone: (___)__________

Females: Last Menstrual Period: ____________ Pregnant? ☐Y ☐N Nursing? ☐Y ☐N Fax: (___)__________

Employer: ________________________ Occupation: ________________________ Work Phone: (___)__________

Employer Address: ________________________ City: ________________ State: __________ Zip: ______________

Name of Spouse, Parent or Guardian: ______________________ Age: _____ Birth Date: __________ SS# _____-_____-_____

Spouse's Employer: ____________________ Spouse's Occupation: ________________ Work Phone: (___)__________

In case of an Emergency Contact: ____ Relationship: ____________

Home Phone: (___) ____________ Cell Phone: (___) ____________ Work Phone: (___) ____________

Do you have Medicare Insurance? ☐Y ☐N Plan/Group #: ______________________ ☐ Medicare card copied by Office Staff

☐ Drivers license copied by Office Staff

How did you hear about our Clinic? Whom may we thank for referring you?____

HEALTH CONCERNS: Please list your top health concerns in order of priority.

1) ____

2) ____

3) ____

4) ____

TREATMENT: What type of treatment are you looking for?

☐ I am looking for the most minimal amount of care to "Patch up the symptoms" of my problem.

☐ I am looking to resolve my symptoms and then go on to "Fix the cause" of my problem.

☐ I am looking to take care of my problem and then go on to "achieve optimal health and wellness."

COMPLAINT/PROBLEM: In relation to your primary complaint:

When did you first seek treatment for this problem? ________________ Has another doctor(s) treated you for this condition: ☐Y ☐N

If yes, whom? ____ Treatment(s): ______________________________

Have you had any intolerance or reactions to treatments? ☐Y ☐N Describe: ______________________________

If this is a recurrence, when was the first time you noticed this problem? ______________________________

How did it originally occur? ____________________ Has it become worse recently? ☐Y ☐N ☐Same ☐Better ☐ Gradually worse

How frequent is the condition? ☐Constant ☐Daily ☐Intermittent ☐Night only How long does it last? ☐All day ☐Few hours ☐ Minutes

Is this condition interfering with your: ☐ Work ☐Sleep ☐Daily routine ☐Recreation ☐Other: ____________________

How long has it been since you really felt good? ☐Days ☐Weeks ☐Months ☐Years ☐> 10 years

Describe the pain: ☐Sharp ☐Dull ☐Numbness ☐Tingling ☐Aching ☐Burning ☐Stabbing ☐Other: ____________________

What makes the problem worse? ☐Standing ☐Sitting ☐Lying ☐Bending ☐Lifting ☐Twisting ☐Other: ________________

Is there anything that you can do to relieve the problem ☐Y ☐N If yes, describe: ______________________________

If no, what have you tried to do that has not helped? ____

What do you believe is wrong with you? ____

Are there any other conditions or symptoms that may be related to your major symptom? ☐Y ☐N If yes, what? ________________

Have you been in an auto accident? ☐Past year ☐Past 5 years ☐Over 5 years ☐Never

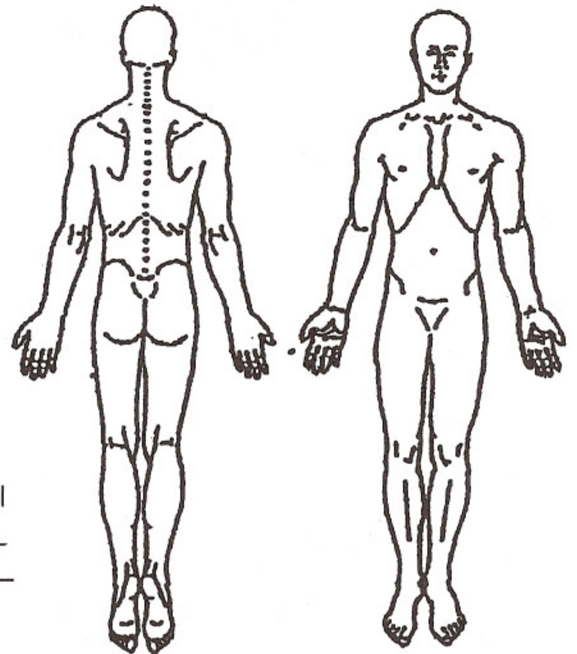
Describe: ____

Please check all of the symptoms that apply. (**P** = Past / **C** = Current)

P / C
☐☐ Headache
☐☐ Facial Pain
☐☐ Eye Pain
☐☐ Blurred Vision
☐☐ Dizziness
☐☐ Earache
☐☐ Forgetfulness
☐☐ Confusion
☐☐ Sinusitis
☐☐ Teeth Grinding
☐☐ Dry Mouth
☐☐ Excessive Thirst
☐☐ Unpleasant Taste
☐☐ Neck Pain
☐☐ Sore Throat
☐☐ Lump in Throat
☐☐ Swallowing Pain
☐☐ Unsteady Voice
☐☐ Shoulder Pain
☐☐ Persistent Coughing
☐☐ Chest Pressure
☐☐ Slow Heart Rate
☐☐ Rapid Heart Rate

P / C
☐☐ High Blood Pressure
☐☐ Low Blood Pressure
☐☐ Abdominal Pains
☐☐ Nausea/Vomiting
☐☐ Poor Appetite
☐☐ Fullness of Bladder
☐☐ Urination Difficulty
☐☐ Frequent Urination
☐☐ Constipation
☐☐ Hemorrhoids
☐☐ Decreased Sex Drive
☐☐ Menstrual Irregularities
☐☐ Elbow / Hand Pain
☐☐ Tingling in Hands
☐☐ Clammy Hands
☐☐ Low Back Pain
☐☐Hip Pain
☐☐ Knee Pain
☐☐ Poor Circulation
☐☐ Swollen Joints
☐☐ Joint Stiffness
☐☐ Swollen Ankles
☐☐ Ankle / Foot Pain

P / C
☐☐ Tingling in Feet
☐☐ Walking Problems
☐☐ Sore Muscles
☐☐ Weak Muscles
☐☐ Paralysis
☐☐ Shakiness
☐☐ Sweating
☐☐ Insomnia
☐☐ Fainting
☐☐ Convulsions
☐☐ Irritability
☐☐ Impatience
☐☐ Fatigue
☐☐ Feel Loss of Control
☐☐ Other: __________
____



Please circle the areas where you are having problems.

ALLERGIES: Please check and list all allergies.

☐ Food: ____________________

☐ Medications: ____________________

☐ Seasonal / Other: ____________________

MEDICATIONS: Please check and list all medications that you are currently taking with the date you began taking them.

	Medication Name	Date Started
☐ Antacids		
☐ Antibiotics		
☐ Antidepressants		
☐ Anti-Diabetics		
☐ Anti-Inflammatory		
☐ Blood Pressure Lowering Meds.		
☐ Cholesterol Lowering Meds.		
☐ Hormone Replacements (HRT)		
☐ Oral Contraceptives		
☐ Other		

SCARS / SURGICAL PROCEDURES: List all scars and surgical procedures you have had. ____________________

____

SUPPLEMENTS: Do you take Vitamins/Supplements or Herbs? ☐Y ☐N If yes, who recommended them? ____________________

HABITS:

	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Soda/Diet Soda	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Stress Level	☐	☐	☐	☐

	5-7x/wk	3-5x/wk	1-3x/wk	None	Type	Time
Exercise	☐	☐	☐	☐		
	8+ hrs	7-8 hrs	6-7 hrs	5-6 hrs	<5 hrs	
Sleep	☐	☐	☐	☐	☐	
	5+	4	3	2		
Meals/day	☐	☐	☐	☐		
	64+ oz	32-64 oz	16-32 oz	<8 oz		
Water/day	☐	☐	☐	☐		

WORK ACTIVITY: ☐Heavy Labor ☐Light Labor ☐Mostly Sitting ☐Mostly Standing ☐Walking/Moving ☐Driving

FAMILY HISTORY: Identify any conditions that you, or any of your family members have now or have had in the past:
(**G** = Grandparents, **M** = Mother, **F** = Father, **S** = Siblings, **X** = Self)

____Alcoholism
____Anemia
____Cancer
____Cold Sores
____Deep Vein Thrombosis
____Detached Retina
____Diabetes
____Eczema
____Emphysema
____Epilepsy
____Goiter
____Gout
____Heart Disease
____HIV / AIDS
____Miscarriage(s)
____Mumps
____Pleurisy
____Pneumonia
____Polio
____Rheumatic Fever
____Stroke
____Tumor(s)
____Ulcer(s)
____Other: ____________________
____
____