Maple Chiropractic New Patient Questionnaire

Dr. Nicole Granert
1000 S. Maple Ave., Glen Rock, NJ 07452

Patient's Name:_____ **Today's Date**:_____

Date of Birth: _____ Age:_____ Sex: M F O

Address:_____ City:_____ State:_____ Zip Code:_____

Phone (Home):_____ (Cell): _____

Email:_____

Marital Status: S M W D Partner's Name (if applies): _____

Children's Names & Ages: _____

Occupation: _____ Company/Employer:_____

Primary Language: _____

Current Weight: _____ Current Height: _____

Emergency Contact Name & Number: _____

Past Chiropractor: _____ Last Visit: _____

Who may we thank for your referral? :_____

Health Report:

Reason for Seeking Care: _____

Present Condition due to an injury: Yes____ No____ On the Job____ Auto Accident ____ Other_____

Has the accident been reported: Yes_____ No _____

Please Circle degree of pain, 0 no pain, 10 severe pain:

0 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

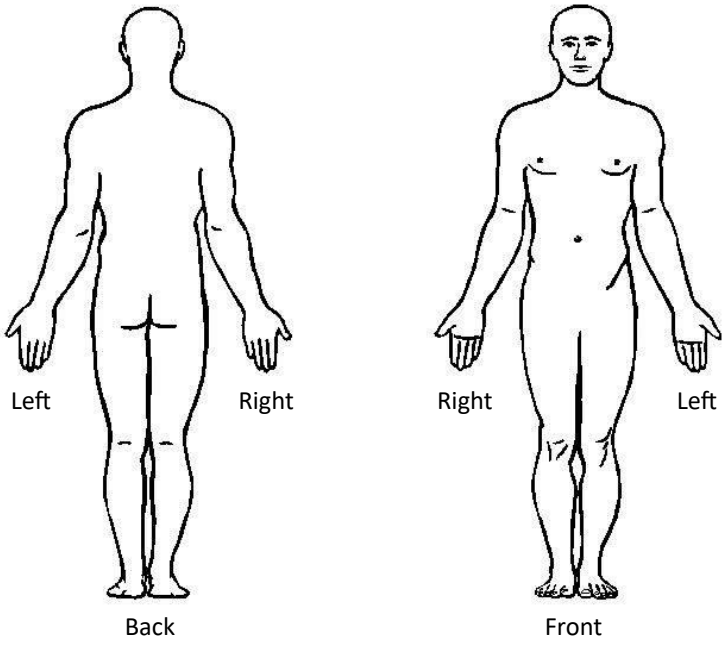
Is your condition interfering with – Work ? _____ Sleep? _____ Daily Routine? _____

Other? _____

Is your condition/pain getting worse? _____

List any other doctors seen for your condition/pain: _____

Circle Areas of Pain:



Activities of Daily Living: please circle any activities the cause pain or you are unable to perform:

Bending, Caring for Children, Carrying, Climbing, Dressing, Putting on Shoes, Driving, Exercising, Lifting, Laying Down, Sleeping, Household chores, Pushing, Pulling, Rolling Over in Bed, Running, Sitting, Sit to Stand, Standing, Walking, Watching TV, Computer Work, Working, Using the Bathroom

Have you had any similar injuries before? Yes: _____ No: _____ If yes, explain:

_____

Please list any allergies: _____

Are you currently taking any medications? Yes: _____ No: _____

List current medications with frequency and dose:

_____

List any surgeries and treated conditions with approximated date:

_____

Have you ever been diagnosed with cancer, heart disease or any other chronic condition?

Yes: _____ No: _____ If yes, specify: _____

Do you smoke? Yes: _____ No: _____ Have you smoked in the past? _____

If yes, specify: _____

Packs per day? _____ How many years? _____

Do you consume alcohol? Yes: _____ No: _____

Daily: _____ Weekly _____ Social Occasions: _____ Occasional _____

Do you use recreational drugs? Yes: _____ No: _____

How many cups of caffeinated drinks a day? _____

How many glasses of water per day? _____

Please circle the following:

Exercise: None Moderate Daily Heavy

Work Activity: Sitting Standing Light Labor Heavy Labor

Hours of Sleep per night: _____ Preferred Sleeping position: _____

Eating habit, 0 unhealthy, 10 healthy:

0 1 2 3 4 5 6 7 8 9 10

Stress level, 0 no stress, 10 high stress:

0 1 2 3 4 5 6 7 8 9 10

Stressors: _____

<u>For Women</u>:

Are you pregnant? Yes: _____ No: _____

If yes, how many weeks? _____ If no, date of last period: _____

Are you trying to get pregnant? Yes: _____ No: _____

<u>Family Health History:</u> Health conditions, age, age of death and cause of death.

Father: _____

Mother: _____

Brother's/Sister's: _____

Children: _____

Please check the boxes if you HAVE or HAD any of the listed conditions							
Musculoskeletal		**Cardiovascular**		**Endocrine**		**Respiratory**	
☐	No Issues	☐	No Issues	☐	No Issues	☐	No Issues
☐	Osteoporosis	☐	High Blood Pressure	☐	Thyroid Issues	☐	Asthma
☐	Arthritis	☐	Low Blood Pressure	☐	Immune Disorders	☐	Apnea
☐	Scoliosis	☐	High Cholesterol	☐	Hypoglycemia	☐	Emphysema
☐	Neck Pain	☐	Poor Circulation	☐	Frequent Infection	☐	Hay Fever
☐	Back Problems	☐	Angina	☐	Swollen Glands	☐	Shortness of Breath
☐	Hip Disorders	☐	Excessive Bruising	☐	Low Energy	☐	Pneumonia
☐	Knee Injuries	☐	Other	☐	Other	☐	Other
☐	Elbow/Wrist Pain						
☐	TMJ Issues	**Digestive**		**Genitourinary**		**Integumentary**	
☐	Foot/ankle Pain	☐	No Issues	☐	No Issues	☐	No Issues
☐	Poor Posture	☐	Anorexia/Bulimia	☐	Kidney Stones	☐	Skin Cancer
☐	Shoulder Problems	☐	Ulcer	☐	Infertility	☐	Psoriasis
☐	Other	☐	Food sensitivities	☐	Bedwetting	☐	Eczema
Neurological		☐	Heartburn	☐	Prostate Issues	☐	Acne
☐	No Issues	☐	Constipation	☐	Erectile Dysfunction	☐	Swollen Glands
☐	Anxiety	☐	Diarrhea	☐	PMS Symptoms	☐	Rash
☐	Depression	☐	Other	☐	Other	☐	Other
☐	Headache	**Sensory**		**Constitutional**			
☐	Dizziness	☐	No Issues	☐	No Issues		
☐	Pins and Needles	☐	Blurred Vision	☐	Fainting		
☐	Numbness	☐	Ringing in Ears	☐	Low Libido		
☐	Other	☐	Hearing Loss	☐	Poor Appetite		
		☐	Loss of Smell	☐	Fatigue		
		☐	Loss of taste	☐	Erectile Dysfunction		
		☐	Chronic Ear Infection	☐	Weakness		
		☐	Other	☐	Other		

Please explain any items you checked above:	
ITEM	**EXPLANATION**

Patient Signature: _____ **Date:** _____

Doctor's Signature: _____ **Date:** _____