Goddard Chiropractic Clinic *New Patient Information Worksheet*

Last Name:_____,**First** _____,**M.I.**____ **SS#:** ____-___-____ **Age:** _____

Address: _____ **City:**_____ **State:** _____ **Zip:**_____

Home Phone:____-____-____ **Work:** ____-____-____ **Birth Date:** _____

Employed By: _____ **Spouse's Name:**_____

Spouse's Birth Date: _____ **Spouse's SS#:** _____-____-_____

Referred By: (Friend) (Relative) (Newspaper Ad) (Yellow Pages) (Sign) (Location) (Other)

Which one of our patient's should we thank for referring you? _____

Please circle your current symptoms:

(Headaches)(Neck Pain)(Neck Stiffness)(Allergies)(Shoulder/Arm Pain)(lf/rt) (Upper-Back Pain) (Mid-Back Pain)(Low-Back Pain)(Hip/Pelvis Pain)(lf/rt)(Sinus Problems)(Asthma)(Stomach Pn) (Chest Pain) (Numbness) (Arthritis) (Sciatica) (Stress) (Other:_____).

My symptoms are due to: (Auto Accident) (Work Accident) (Home Accident) (Sports)(Other)

List all Surgeries in the past five years:_____

Have you ever had spinal surgery? (No) (Yes) If yes Where_____ By Whom_____

List any serious condition the doctor should be aware of:_____

Previous Chiropractor:_____ **Were you satisfied ?** (No) (Yes)

***Females: Are you pregnant at this time ?** (No) (Yes) (Not Sure) **Due Date:**_____

Office Policies: *If I am accepted as a patient at Goddard Chiropractic I agree to pay for all services, including services not covered by my insurance company. If I suspend (or terminate) my treatment without the doctor's permission, it will be understood that I have reached maximum healing for my condition. I then agree to be fully responsible for my condition and future care. I understand that no medical records or x-rays will be released from this office if I owe any money on my account.*

Consent To Treat: *I also understand that no cures are promised (or implied) and any risk regarding care at this office will be explained to me upon my request. I now authorize Dr. Villegas or associate doctor to proceed with any necessary treatment. I have read Dr Villegas's office policies and consent to treat information, and I agree with them by signing below.*

Signature:_____ **Date:**_____

Parent/Guardian's Signature:_____ **Date:**_____

Goddard Chiropractic Clinic

Dr. Israel Villegas [redacted]

316-794-8410 * Fax 316-794-8466

701 N. Goddard Rd, P.O. Box 436

Goddard, KS 67052-0436

Patient's Name_____ **Date:**_____

*[Please **circle the number** which most closely describes your chief complaint(s) today:*

1. Pain Intensity

(0)	(1)	(2)	(3)	(4)
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

2. Frequency Of Pain

(0)	(1)	(2)	(3)	(4)
No Pain	Occasional Pain 25% Of The Day	Intermittent Pain 50% Of The Day	Frequent Pain 75% Of The Day	Constant Pain 100% Of The Day

3. Personal Care (Washing, Dressing, etc.)

(0)	(1)	(2)	(3)	(4)
No Pain No Restrictions	Mild Pain No Restrictions	Moderate Pain Need to go slowly	Moderate Pain Need some assistance	Severe Pain Need 100% Assistance

4. Travel (Driving, Riding, etc.)

(0)	(1)	(2)	(3)	(4)
No Pain On Long Trips	Mild Pain On Long Trips	Moderate Pain On Long Trips	Moderate Pain On Short Trips	Severe Pain On Short Trips

5. Work

(0)	(1)	(2)	(3)	(4)
Can Do Usual Work Plus Extra Work	Can Do Usual Work No Extra Work	Can Do 50% Of Usual Work	Can Do 25% Of Usual Work	Cannot Work

6. Recreation

(0)	(1)	(2)	(3)	(4)
Can Do All Activities	Can Do Most Activities	Can Do Some Activities	Can Do A Few Activities	Cannot Do Any Activities

7. Sleeping

(0)	(1)	(2)	(3)	(4)
Perfect Sleep	Mildly Disturbed	Moderately Disturbed	Greatly Disturbed	Totally Disturbed

8. Lifting

(0)	(1)	(2)	(3)	(4)
No Pain With Heavy Weight	Increased Pain With Heavy Weight	Increased Pain With Moderate Weight	Increased Pain With Light Weight	Increased Pain With Any Weight

9. Walking

(0)	(1)	(2)	(3)	(4)
No Pain Any distance	Increased Pain After One Mile	Increased Pain After Half Mile	Increased Pain After Quarter Mile	Increased Pain With All Walking

10. Standing

(0)	(1)	(2)	(3)	(4)
No Pain After Several Hours	Increased Pain After Several Hours	Increased Pain After One Hour	Increased Pain After Half Hour	Increased Pain With Any Standing

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Patient Health History Worksheet

Patient's Name:_____ Date:_____

Present Health History

When did your present condition begin?
a) Gradual Onset (no specific date)
b) Date:_____

What caused your present condition?
a) No specific injury
b) Home accident
c) Work Accident
d) Auto Accident

What happened to cause your present pain?
_____
_____
_____
_____
_____

Have you ever had these symptoms before?
a) No
b) Yes: (Date:_____)

What time of day are your symptoms **better**?
a) Morning
b) Afternoon
c) Evening
d) None of the above (constant pain)

What time of day are your symptoms **worse**?
a) Morning
b) Afternoon
c) Evening
d) All of the above (constant pain)

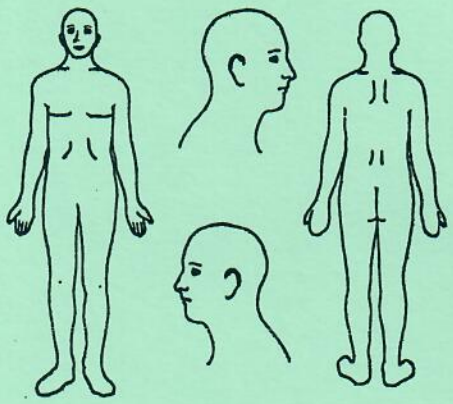
Have you missed any work from this condition?
a) No
b) Yes: (Date:_____)

What makes your pain **better**?
a) Rest
b) Ice packs/Heating pads
c) Prescription Medications
d) Drug store medications (Ibuprofen, Advil)
e) Other: _____

What makes your pain **worse**?
a) Activity (work, repetitive motions)
b) Ice packs/Heating pads
d) Driving (or riding) in car
e) Other: _____

What home remedies have you tried?
a) Ice packs
b) Heating pads/Hot tubs
c) Exercise
d) Other: _____

Please Label The Area(s) Of Today's Pain



_____
_____
_____
_____
_____

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Patient Health History Worksheet

Patient's Name:_____ Date:_____

Significant Past Health History

Have you ever been hospitalized?
a) No
b) Yes: (Year:_____) (Reason:_____)

Have you had any surgeries?
a) No
b) Yes: (Year:_____) (Reason:_____)

Do you have any significant health problems?
a) No
b) Yes: (_____)

Significant Past Medical History

Have you seen another doctor for this condition?
a) No
b) Yes: (Name:_____)

Did this doctor recommend any treatment?
a) No
b) Yes: (_____)

Are you taking any medications?
a) No
b) Yes: (_____)

Significant Past Social History

Do you play any sports or exercise?
a) No
b) Yes: (_____)

How many hours do you sleep a night? (_____)

How many hours a week do you work? (_____)

Significant Family Medical History

Did your father have any health problems?
a) No
b) Yes: (_____)

Did your mother have any health problems?
a) No
b) Yes: (_____)

Did your brother(s) have any health problems?
a) No
b) Yes: (_____)

Did your sister(s) have any health problems?
a) No
b) Yes: (_____)

Did your grandpa have any health problems?
a) No
b) Yes: (_____)

Did your grandma have any health problems?
a) No
b) Yes: (_____)

Health Risk Factors

Do you drink alcohol?
a) No
b) Yes: (_____)

Do you smoke?
a) No
b) Yes: (_____)

Anything else the doctor should know about?
a) No
b) Yes: (_____)