



# TOLMAN CHIROPRACTIC

## New Patient History Form

Patient Name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Chief Complaint: Injury: Work related Auto related Other; Repetitive or Traumatic, Gradual or Sudden Onset  
Date your symptoms first began (this episode)\_\_\_/\_\_\_/\_\_\_ Have you experienced these symptoms prior? Yes No  
Is your condition getting worse? Yes No Unknown. Are your symptoms constant? Yes No Comes and goes  
Does it interfere with: Work Sleep Driving Daily Routine Recreation A.M. P.M. Other \_\_\_\_\_  
What makes your symptoms worse? Standing Sitting Walking Bending Lifting Other \_\_\_\_\_  
Have you been treated for this problem? Yes No If yes, by whom? \_\_\_\_\_  
What was the recommendation/treatment? \_\_\_\_\_

Are there any other areas/conditions of complaint? \_\_\_\_\_

What is your occupation? \_\_\_\_\_ Briefly describe your daily activities \_\_\_\_\_

List dates and reasons for hospitalizations/surgeries? \_\_\_\_\_

List any serious illnesses with dates: \_\_\_\_\_

Briefly describe any previous auto accidents, or other injuries; including dates: \_\_\_\_\_

Have you received Chiropractic Care before? Yes No If so, when \_\_\_/\_\_\_/\_\_\_ for what condition \_\_\_\_\_

Date of last: Physical Exam \_\_\_/\_\_\_/\_\_\_ Spinal X-Ray \_\_\_/\_\_\_/\_\_\_ Other Imaging \_\_\_/\_\_\_/\_\_\_  
Breast Exam/Mammogram (women) \_\_\_/\_\_\_/\_\_\_ Prostate Exam (men) \_\_\_/\_\_\_/\_\_\_

Have you... Had a broken bone? \_\_\_\_\_ Been treated for a spinal disorder? An implant or pacemaker? Had a Hernia?

**Women only:** are you pregnant? Yes No Date of last menstrual period \_\_\_/\_\_\_/\_\_\_ or # Weeks Gestation \_\_\_\_\_ # of births \_\_\_\_\_

Do you exercise? (Non work exercise only) Yes No If yes, what type of exercise? \_\_\_\_\_

How often? \_\_\_/Week, Duration? \_\_\_\_\_ minutes. How many glasses/oz. of water do you drink a day? \_\_\_\_\_ Soda? \_\_\_\_\_

How many hours do you sleep nightly? \_\_\_\_\_ Restful? Yes No Do you sleep on your Stomach, Back, or Side?

Do you Smoke? Yes No How much? \_\_\_\_\_ day/week Do you drink alcohol? Yes No If yes, how much? \_\_\_\_\_ day/week

Do you take: Muscle Relaxers? Painkillers? Insulin? Birth control pills? Over-the-counter medications? Other prescription drugs?

**Medications:** List all medication currently taking and the reason for taking them. **Vitamins/Minerals/Herbals:** List all supplements with daily dose


I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_  
Or  
Parent/Guardian: \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_