File # ________________

## NEW PATIENT QUESTIONNAIRE

Name ______________________________________________________ Date ________________

Address ______________________________________________________________________

City __________________________ State ______ Zip ________ Soc. Sec. # ______________________

Home Phone ____________________ Cell ______________________ Work ______________________

E-mail address ________________________________________ Fax ______________________________

Preferred method of contact: ☐ Home ☐ Office ☐ Cell Phone ☐ Fax ☐ E-Mail ☐ Text

Would you prefer an appointment reminder by ☐ E-Mail or ☐ Text

Occupation ______________________________ Employer ______________________________________

Date of Birth ______________________ Age _____________ Gender: M____ F____

Race: ☐ White ☐ Black or African American ☐ Asian

☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific

☐ Some Other Race

Preferred Language: ☐ English ☐ Other

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

In Case of Emergency Notify __________________________________ Phone ____________________

Primary Care Physician ______________________________________ Phone ____________________

Parent/Guardian if Under 18 ____________________ Medical Insurance ____________________________

How did you hear about our office? _________________________________________________________

**Andrew B. Levin, D.C.**
**33913 U. S. 19 North**
**Palm Harbor, Florida 34684**
**727-789-2663 Fax 727-787-1529**

Name ______________________________ File#: ___________

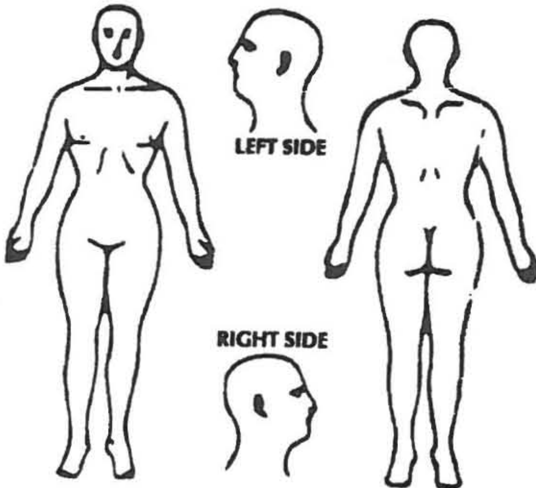
Please describe the health problem for which you came to our office.

_______________________________________________

_______________________________________________

_______________________________________________

Shade in the areas on the diagram where you feel discomfort or symptoms.




_______________________________________________

When did **this** episode of symptoms begin? ______________________

_______________________________________________

_______________________________________________

Describe how symptoms began (unknown, fall, lifting, etc. be specific)

_______________________________________________

_______________________________________________

Did symptoms begin ☐ Suddenly ☐ Gradually

Describe the character of your symptoms (ex. burning, sharp, tingling, numb, etc.)

_______________________________________________

_______________________________________________

Name______________________________ File #: __________

Indicate the **severity** of your complaint by circling a number on the scale.

What is your pain RIGHT NOW?

No Pain Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

What is your TYPICAL or AVERAGE pain?

No Pain Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

What is your pain level AT ITS WORST?

No Pain Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

Since your symptoms began, have they ☐ improved ☐ worsened ☐ stayed the same

What aggravates or worsens your symptoms? ______________________________

______________________________

Do your symptoms limit your sleep or wake you up? ______________________________

Describe any previous episodes of **this** or **similar** complaints. ______________________________

______________________________

List any doctors or any treatment for this or similar conditions (include self treatment):

______________________________

______________________________

Have you ever been treated by a Chiropractor? ☐ Yes ☐ No Name ______________________________

Have you been treated for any health condition in the last year? ☐ Yes ☐ No

Describe ______________________________

______________________________

Name______________________________ File #: ____________

List **ANY** other significant present or past health problems.

______________________________________________________________________

List **ANY** other significant present or past injuries. Ex. Broken Bones, Car accident, etc.

______________________________________________________________________

Have you had any significant problems with the following?

| | | | | | |
|---|---|---|---|---|---|
| Eyes | ☐ yes | ☐ no | Musculoskeletal | ☐ yes | ☐ no |
| Ears, nose, mouth, throat | ☐ yes | ☐ no | Skin | ☐ yes | ☐ no |
| Cardiovascular | ☐ yes | ☐ no | Neurologic | ☐ yes | ☐ no |
| Respiratory | ☐ yes | ☐ no | Psychiatric | ☐ yes | ☐ no |
| Gastrointestinal | ☐ yes | ☐ no | Hematologic/lymphatic | ☐ yes | ☐ no |
| Genitourinary | ☐ yes | ☐ no | Immunologic | ☐ yes | ☐ no |

______________________________________________________________________

______________________________________________________________________

List **any** surgical procedures you have had. List year if known ______________________________

______________________________________________________________________

List **any** medications or supplements you are currently taking.______________________________

______________________________________________________________________

______________________________________________________________________

List any allergies. ______________________________________________________

______________________________________________________________________

How much liquor do you consume on a weekly basis? ______________________________

**Smoking Status**:

☐ Current every day Smoker ☐ Current some day Smoker

☐ Former Smoker ☐ Never Smoked

☐ Smoker current status unknown ☐ Unknown if ever smoked

Name_______________________________ File #: ___________

What is your height? ___________ What is your weight? ___________

What type of exercise do you perform? _______________________________________________

_______________________________________________________________________________

What do your daily work habits include? (ex. sitting, standing, light labor, heavy labor, computer work)

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

**Family History**: Describe any significant health conditions in your immediate family.

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

The above information is accurate to the best of my knowledge.

**Please sign:** ___________________________________________