

# Pathway Wellness Chiropractic Clinic

Tallahassee, FL

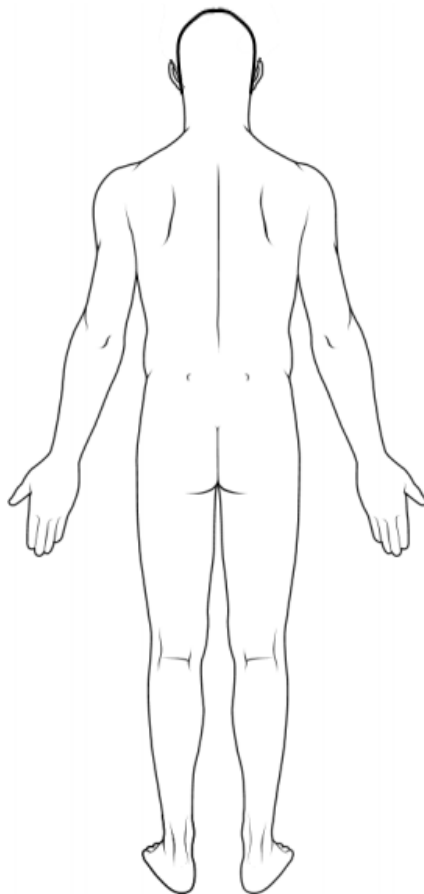
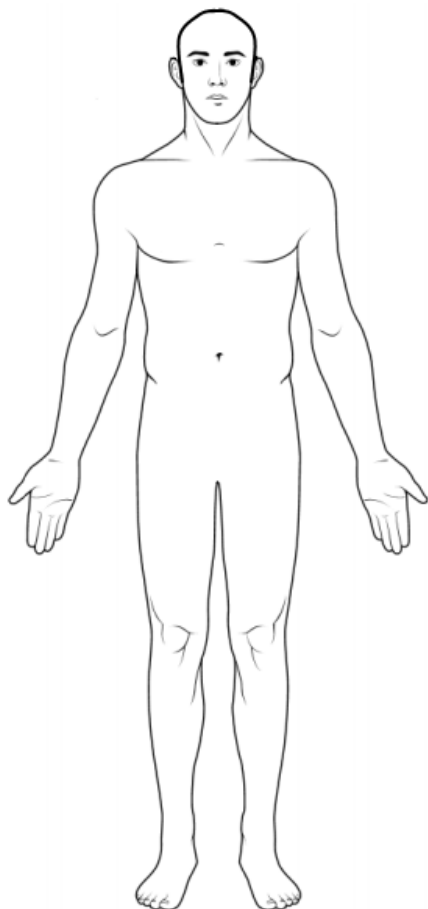
## New Patient History Form

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date \_\_\_\_\_  
Last 4 of SSN \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Primary Phone Number \_\_\_\_\_ Cell Phone Carrier \_\_\_\_\_  
Email address \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
How did you hear about our clinic? \_\_\_\_\_ Have you been to a chiropractor before? \_\_\_\_\_  
If yes how did you respond \_\_\_\_\_

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**Please Mark Your Areas of Pain on the Diagram Below**



### Type of Pain:

- Sharp/Stabbing
- Burning
- Ache
- Dull
- Numb/Tingling
- Other \_\_\_\_\_

**Describe your main concern below:**

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**Section B** Please use a **yes** or **no** when answering any of the following. If you are not sure leave a ? .

- |   |  |
|---|--|
| <input type="checkbox"/> Do you have a personal history of cancer?      | <input type="checkbox"/> Do you have osteoporosis?                               |
| <input type="checkbox"/> Have you had any unexplained weight loss?      | <input type="checkbox"/> History of prolonged use of corticosteroids?            |
| <input type="checkbox"/> Recent trouble starting or stopping urination? | <input type="checkbox"/> Do you have a connective tissue disorder?               |
| <input type="checkbox"/> Recent trouble with bowel movements?           | <input type="checkbox"/> Current or recent infection?                            |
| <input type="checkbox"/> Numbness in the groin region?                  | <input type="checkbox"/> History of immunosuppression medication &/or condition? |
| <input type="checkbox"/> Recent muscle weakness in the legs?            | <input type="checkbox"/> Do you have hypertension?                               |
| <input type="checkbox"/> History of significant trauma?                 | <input type="checkbox"/> Do you smoke?   |

### PAST HISTORY

**PREVIOUS INJURIES** (Please give dates, describe injury and care received)

**AUTO:** \_\_\_\_\_  
\_\_\_\_\_

**WORK RELATED:** \_\_\_\_\_  
\_\_\_\_\_

**PERSONAL:** \_\_\_\_\_  
\_\_\_\_\_

**LIST ALL SURGERIES:** \_\_\_\_\_  
\_\_\_\_\_

**CURRENT MEDICAL CONDITIONS:** ie. (diabetes, high blood pressure, high cholesterol, etc)  
\_\_\_\_\_  
\_\_\_\_\_

**LIST ALL MEDICATIONS/VITAMINS:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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### REVIEW OF SYSTEMS

Please use the numbers below when answering. If you have never had the condition, please leave blank.

1. Current
2. Related to auto accident

#### GENERAL SYMPTOMS

- Headache
- Fever
- Chills
- Night Sweats
- Fainting
- Dizziness
- Fatigue
- Nervousness
- Loss of Weight
- Numbness or pain in arms/legs/hands

#### MUSCLE & JOINTS

- Weakness
- Stiff Neck
- Backache
- Swollen Joints

#### GASTRO-INTESTINAL

- Nausea
- Vomiting
- Vomiting Blood
- Constipation
- Diarrhea

#### CARDIO VASCULAR

- High Blood Pressure
- Low Blood Pressure
- Heart Trouble
- Swelling Ankles
- Poor Circulation
- Varicose Veins
- Strokes

#### EYE/EAR/NOSE/THROAT

- Poor Vision
- Pain in Eyes
- Earache
- Ear Noises
- Nose Bleeds

#### SKIN/ALLERGIES

- Bruising Easily
- Sensitive Skin
- Hives or Allergies
- Eczema

#### RESPIRATORY

- Chronic Cough
- Spitting Blood
- Chest Pain
- Difficult Breathing

#### GENTO-URINARY

- Painful Urination
- Blood in Urine
- Kidney Infection
- Inability to control urine

Other conditions not listed above:

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I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Date \_\_\_\_\_

Signature of patient (or parent of minor)