New Patient Health Form Ascent Health

Patient Information

Date: _____

Patient Last Name _____

First Name _____ MI _____

Address _____

City _____ State _____ Zip _____

Email _____

Sex ☐M ☐F Age _____

Birthdate _____ /_____ /_____

Height _____ Weight _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ year

Occupation _____

Patient Employer/School _____

Employer/School Address, _____

Employer/School Phone L _____

Spouse's Name _____

Birthdate _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Insurance Information

What you hoping to achieve here at Ascent Health? _____

Phone Numbers

Home _____

Cell _____

Best time and place to reach you, _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home L _____

Work L _____

Accident Information

Is condition due to an accident ☐ YES ☐ NO

Date of accident _____

Type of accident ☐ auto ☐ work ☐ home ☐ other ___

To whom have you made a report of your accident?

☐ auto insurance ☐ employer

☐ work comp ☐ Other

Attorney name (if applicable).

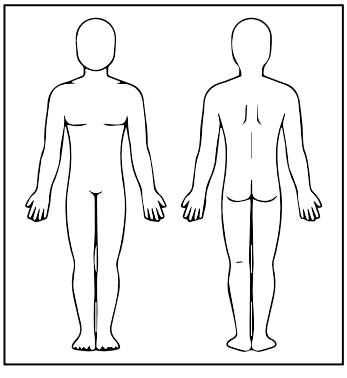
Patient Condition

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ YES ☐ NO ☐ Unknow

Mark an x on the picture where you continue to have pain, numbness or tingling



Rate severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of Pain ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting

Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

How often do you have this pain _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ work ☐ sleep ☐ daily routine ☐ recreation

Activities or movements that are painful to perform ☐ sitting ☐ standing ☐ walking ☐ bending ☐ lying

Health History

What treatment have you already received for your condition? ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other

Name and address of other doctor(s) who have treated you for your condition

Date of Last Physical Exam _____ Spinal X-ray _____ Blood Test _____ Spinal Exam _____

Chest X-Ray _____ Urine Test _____ Dental X-Ray _____ MRI, OT-Scan, Bone Scan, _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ YES ☐ NO	Glaucoma	☐ YES ☐ NO	Pneumonia	☐ YES ☐ NO
Alcoholism	☐ YES ☐ NO	Goiter	☐ YES ☐ NO	Polio	☐ YES ☐ NO
Allergy Shots	☐ YES ☐ NO	Gout	☐ YES ☐ NO	Prostate Problem	☐ YES ☐ NO
Anemia	☐ YES ☐ NO	Heart Disease	☐ YES ☐ NO	Prosthesis	☐ YES ☐ NO
Anorexia	☐ YES ☐ NO	Hepatitis	☐ YES ☐ NO	Psychiatric Care	☐ YES ☐ NO
Appendicitis	☐ YES ☐ NO	Herniated Disk	☐ YES ☐ NO	Rheumatoid Arthritis	☐ YES ☐ NO
Arthritis	☐ YES ☐ NO	Herpes	☐ YES ☐ NO	Rheumatic Fever	☐ YES ☐ NO
Asthma	☐ YES ☐ NO	High Cholesterol	☐ YES ☐ NO	Scarlet	☐ YES ☐ NO
Bleeding Disorders	☐ YES ☐ NO	Kidney Disease	☐ YES ☐ NO	Stroke	☐ YES ☐ NO
Breast Lump	☐ YES ☐ NO	Liver Disease	☐ YES ☐ NO	Suicide Attempt	☐ YES ☐ NO
Bronchitis	☐ YES ☐ NO	Measles	☐ YES ☐ NO	Thyroid Problems	☐ YES ☐ NO
Bulimia	☐ YES ☐ NO	Migraines	☐ YES ☐ NO	Tonsillitis	☐ YES ☐ NO
Cancer	☐ YES ☐ NO	Miscarriage	☐ YES ☐ NO	Tuberculosis	☐ YES ☐ NO
Cataracts	☐ YES ☐ NO	Mononucleosis	☐ YES ☐ NO	Tumors, Growths	☐ YES ☐ NO
Chemical Dependency	☐ YES ☐ NO	Multiple Sclerosis	☐ YES ☐ NO	Typhoid Fever	☐ YES ☐ NO
Chicken Pox	☐ YES ☐ NO	Mumps	☐ YES ☐ NO	Ulcers	☐ YES ☐ NO
Diabetes	☐ YES ☐ NO	Osteoporosis	☐ YES ☐ NO	Vaginal Infections	☐ YES ☐ NO
Emphysema	☐ YES ☐ NO	Pacemaker	☐ YES ☐ NO	Venereal Disease	☐ YES ☐ NO
Epilepsy	☐ YES ☐ NO	Parkinson's Disease	☐ YES ☐ NO	Whooping Cough	☐ YES ☐ NO
Fractures	☐ YES ☐ NO	Pinched Nerves	☐ YES ☐ NO	Other	☐ YES ☐ NO

Exercise

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

Work Activity

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

Habits

- ☐ Smoking — Packs per Day _____
- ☐ Alcohol — Drinks per Week _____
- ☐ Coffee/Caffeine Drinks — Cups per Day _____
- ☐ High Stress Level — Reason _____

Are you pregnant? ☐ YES ☐ NO **Date:** _____

Injuries/Surgeries you have had

Falls _____

Head Injuries _____

Broken Bones _____

Dislocations _____

Surgeries _____

Medications

_____

_____

_____

_____

Pharmacy _____

Pharmacy Phone (____ **)** _____

Allergies

_____

_____

_____

_____

_____

_____

_____

Vitamins/Herbs/Minerals

_____

_____

_____

_____

_____

_____

_____