Meints Chiropractic & Wellness PA
500 S Main Street Pine Island, Minnesota 55963

NEW PATIENT QUESTIONNAIRE

First Name_____ Middle _____ Last Name_____ Date_____
Address_____ City_____ State _____
Zip_____ Spoken Language – English/Spanish/Other_____ Race _____
Home Phone _____ Cell Phone _____ Work Phone _____
Birth Date_____ Marital Status: M S W D How many children_____
Occupation _____ Employer _____
Email Address _____ Gender: Male / Female
Referred by_____ Past chiropractic care? Y N When?_____
Who to contact in emergency? _____ Phone _____
Emergency Contact Relationship _____

Current problem(s): _____
_____

Is this a workers compensation case? Y N Auto/Personal Injury/other accident? Y N

List **car accidents/major injuries** you have had _____
_____

List any **diseases** you have had _____
_____

List **operations** you have had _____
_____

List **medications/drugs** you take _____
_____

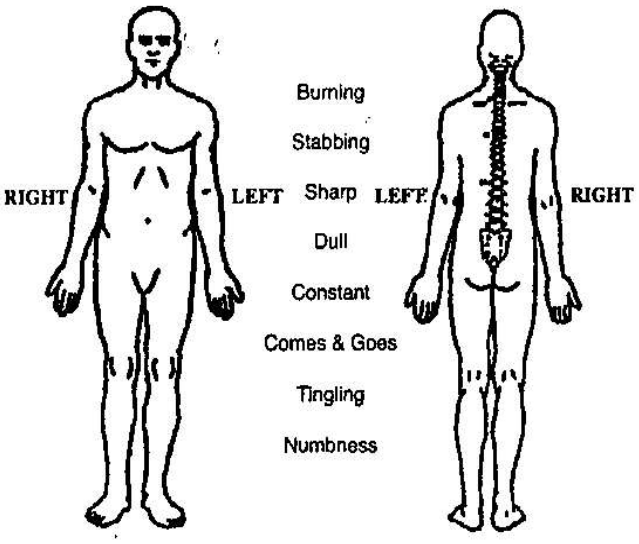
Last time you saw a medical doctor? _____

Health Habits:
Smoke? Y N _____packs/day
Alcohol? Y N _____drinks/day
Coffee? Y N _____cups/day
Pop? Y N _____cans/day
Water? Y N _____glasses/day
Milk? Y N _____glasses/day
Vitamins? Y N _____
Exercise? Y N _____

Family History:

	Diabetes	Heart	Kidney	Cancer	Back
Mother	____	____	____	____	____
Father	____	____	____	____	____
Brother(s)	____	____	____	____	____
Sister(s)	____	____	____	____	____

Mark your pain areas on these figures



FOR DOCTORS USE ONLY
Ht _____ Wt_____ BP_____/_____ Pulse_____ Temperature _____

Doctor's Signature: _____ Date: _____

Patient ID Number _____

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HISTORY OF THIS PROBLEM

Patient Name _____ Patient ID#_____

1. When was the **first time** you ever had this problem? ____ This is the first time

2. Did anything specific **cause** it that first time? N Y (Explain if yes)

3. **How many times** have you had this problem occur?

4. **When** did **this** episode of pain begin and **what** caused it?

5. **Describe your pain**: (circle) Mild Moderate Severe (circle all others below that apply)

   ache sharp shooting burning stabbing gnawing numb tingling other

6. How **frequent** is the pain? (circle one) constant comes & goes worse with movement

7. When is the problem **most intense**? day night early and late in the day

8. Does the pain **radiate**? Y N (circle where the pain/numbness/tingling goes below)

   head shoulder upper arm lower arm hand around chest
   buttock upper leg knee lower leg foot

9. Are there any **problems** with these organs since your problem began? (circle which ones)

   bowel bladder female organs stomach lungs heart male organs head

10. What **home treatments** have you tried?

    heat ice massage stretches exercises medicines (ie. Aspirin) rest

11. Mark **actions** which Aggravate (A) or Relieve (R): sitting____ standing____ walking____ laying____ changing positions____ bending____ riding____ cough____ sneeze____ strain____

12. Are you **better**, **worse**, or the **same** now? (circle) Better Worse Same

FOR DOCTORS USE ONLY

Doctor's Signature: _____ Date: _____