ADE MEDICAL GROUP

Chiropractor New Patient Medical History Form

Date:_____

Name:_____ **DOB:**_____ **SSN#:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Phone Number:_____ **E-mail address:**_____

CURRENT COMPLAINT

Where is your pain? _____ **Please Describe:**_____

_____

Date symptoms appeared:_____

Have you ever had same condition? Y or N If yes, when:_____

List other providers seen for this pain:_____

Have you been under Chiropractic Care? Y or N If yes, who and when?_____

Do you experience pain everyday? Y or N

Do your symptoms interfere with daily life? Y or N

Does pain wake you up at night? Y or N

Are your symptoms worse during certain times of the day? Y or N

Do you wear orthotics? Y or N

Do changes in weather affect your symptoms? Y or N

Do you take Vitamin D supplements? Y or N

What activities aggravate your symptoms?_____

_____

HAVE YOU EVER

Broken a bone? Y or N **If yes, explain:**_____

Had Sprains/Strains? Y or N **If yes, explain:**_____

Been in an automobile accident? Y or N **If yes, explain:**_____

Been struck unconscious? Y or N **If yes, explain:**_____

Hospitalizations/Significant injuries:_____

FAMILY HISTORY

FAMILY MEMBER	AGE	LIVING	CAUSE OF DEATH
Father			
Mother			
Brother(s) #			
Sister(s) #			

SURGERY/PROCEDURE HISTORY *(check all that apply)*

- ☐ Appendix
- ☐ Bladder Suspension
- ☐ Colon/Rectal surgery
- ☐ Dental Surgery
- ☐ Eye Surgery
- ☐ Gallbladder
- ☐ Heart Surgery
- ☐ Heart Bypass
- ☐ Heart Valve Surgery
- ☐ Heart Angioplasty (balloon)
- ☐ Heart Stents
- ☐ Heart Pacemaker
- ☐ Hysterectomy
- ☐ Complete ☐ Partial
- ☐ Hernia
- ☐ Joint Replacement
- ☐ Kidney Surgery
- ☐ Organ Transplant
- ☐ Orthopedic Surgery
- ☐ Prostate Surgery
- ☐ Sinus Surgery
- ☐ Thyroid Surgery
- ☐ Tonsils and/ or Adenoids
- ☐ Tubal Ligation ☐ Vasectomy

Other surgery not listed above:_____

Previous reaction to anesthesia: *(explain)*_____

_____

Diseases in the Family: *(check all that apply)*

- ☐ Arthritis
- ☐ Addiction Problems
- ☐ Anxiety/Mental Illness
- ☐ Bleeding Problems
- ☐ Cancer
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Prostate Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ High Cholesterol
- ☐ Liver Disease

MEDICATION LIST

MEDICATION	DOSAGE	HOW OFTEN	DISEASE/REASON	PRESCRIBED BY

ALLERGIES OR REACTIONS

MEDICATION/FOOD/ENVIRONEMENTAL	REACTION

SOCIAL HISTORY

Do you smoke? ☐ Currently: packs/day____ years_____ ☐ Past: Date quit:_____ ☐ Never

Do you use a vape pen? ☐ Currently ☐ Never ☐ Past **Do you use an e-cigarette?** ☐ Currently ☐ Never ☐ Past

If you do smoke, are you interested in quitting? ☐ YES ☐ NO **Other nicotine use?** ☐ YES ☐ NO ☐ Past

Do you drink alcohol? ☐ YES ☐ NO ☐ Beer ☐ Wine ☐ Liquor **How many drinks per week?**_____

How many caffeinated beverages per day?_____ ☐ Coffee ☐ Tea ☐ Soda ☐ Energy Supplements

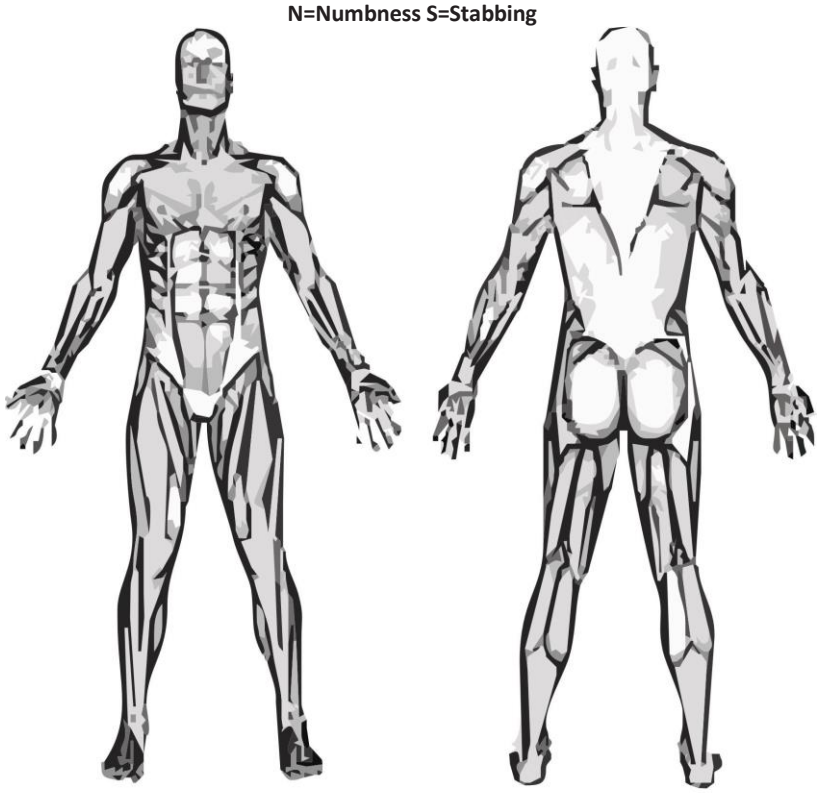
Any recreational drug use? ☐ YES ☐ NO **Type?**_____

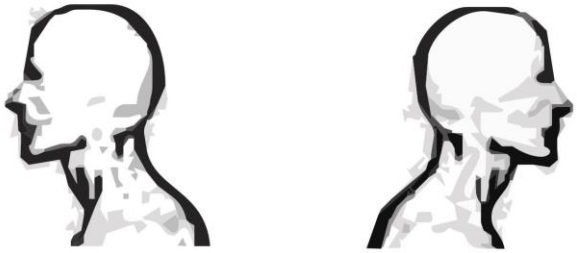
Do you exercise regularly? ☐ YES ☐ NO **If so, how many times per week?**___ **Type of exercise?**_____

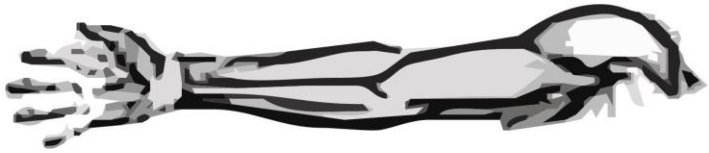
Have you ever suffered from:

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Eye Pain or Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heartbeat
- ☐ Irregular Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of memory
- ☐ Loss of balance
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lumps In Breast
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of breath
- ☐ Sinus Infection
- ☐ Sleep problems or Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swollen Joints / ankles / neck pain or Stiffness / back pain
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.
A=Ache O=Other
B=Burning P=Pins & Needles
N=Numbness S=Stabbing







Please sign below to indicate the above information is accurate to the best of your knowledge

I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable. I understand that all services are cash pay, nonrefundable and my insurance company will not be billed.

Patient Signature:_____ **Date:**_____

Spouse's or guardian's signature:_____ **Date:**_____