ADVANCED CHIROPRACTIC AND SPORTS REHABILITATION CLINIC

DR. JERRILYNN PRIMEAUX

201 WESTMARK BLVD, STE E
LAFAYETTE, LA 70506

NEW PATIENT INFORMATION

Full Name____ Sex M F Date__________________________

Address_____________________________City__________________________________State________Zip__________________

H. Phone____________________________ C. Phone______________________________ W. Phone ____________________________

Date of Birth__________________Age___________ SSN ____________________ Marital Status ____________________________

E-Mail ____Referred by____

Occupation____ Employer____

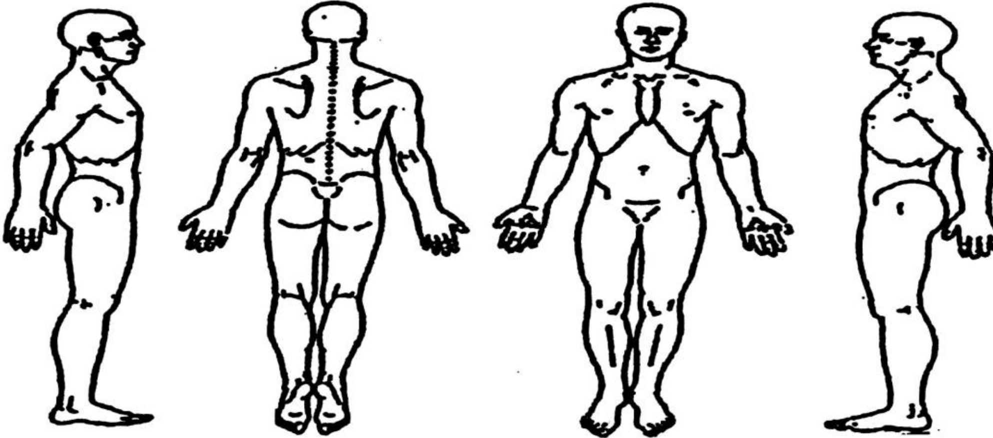
Have you ever received Chiropractic Care? Yes No If yes, when?____

1. Primary reasons for seeking chiropractic care:

Primary reasons: ____

2. Is today's problem caused by: □ Auto Accident □ Workman's Compensation □ Other

3. Indicate on the drawings below where you have pain/symptoms



4. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

5. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:___________________

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6. How are your symptoms changing with time?
□ Getting Worse □ Staying the Same □ Getting Better

7. Using a scale from 0-10 (10 being the worst), how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

8. How much has the problem interfered with your work?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

9. How much has the problem interfered with your social activities?
□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

10. Who else have you seen for your problem?
□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____________
□ Massage Therapist □ Physical Therapist □ No one

11. How long have you had this problem? ___________

12. How do you think your problem began?
____

13. Do you consider this problem to be severe?
□ Yes □ Yes, at times □ No

14. What aggravates your problem?
____

15. What helps your problem?
____

16. What concerns you the most about your problem; what does it prevent you from doing?
____

17. What is your: Height___________ Weight _____________

18. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

19. What type of exercise do you do?
□ Strenuous □ Moderate □ Light □ None

20. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

21. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies

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Past	Present		Past	Present		Past	Present	
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorder	□	□	Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	Dermatitis/Eczema/Rash
□	□	Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Abnormal Weight Gain/Loss			
□	□	Ankle/Foot Pain	□	□	Loss of Appetite			**For Females Only**
□	□	Jaw Pain	□	□	Abdominal Pain	□	□	Birth Control Pills
□	□	Joint Pain/Stiffness	□	□	Ulcer	□	□	Hormonal Replacement
□	□	Arthritis	□	□	Hepatitis	□	□	Pregnancy
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder			
□	□	Cancer	□	□	General Fatigue			
□	□	Tumor	□	□	Muscular Incoordination			
□	□	Asthma	□	□	Visual Disturbances			
□	□	Chronic Sinusitis	□	□	Dizziness			
□	□	Other:______________________________						

22. List all medications (prescribed and over-the-counter) you are currently taking:
____

23. List all nutritional supplements you are currently taking:
____

24. List all surgical procedures you have had:
____

25. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day
□ **Drives:**	□ Most of the day	□ Half of the day	□ A little of the day
□ **Manual Labor:**	□ Most of the day	□ Half of the day	□ A little of the day

26. What activities do you do outside of work?
____

27. Have you ever been hospitalized? □ No □ Yes
if yes, why ____

28. Have you had significant past trauma? □ No □ Yes

29. Anything else pertinent to your visit today?____

Patient Signature_____________________________________ **Date:**_____________________

Doctor's Signature ____________________________________ **Date:**____________________