Abundant Health Arizona
Health, vitality and wellness with ease

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Adult New Patient Application

"A Healthy Spine Means a Healthier You!"

Name_____ Home Phone _____
Address_____ Work Phone _____
City, State, Zip_____ Cell Phone _____
E-mail Address _____
Birth date_____ Age_____ Occupation:_____ Employer _____
Status: ❍Married ❍Widowed ❍Separated ❍Divorced ❍Single Spouse Name_____ No. of Children _____
To conserve resources we generally utilize email and text for regular communication. May we communicate with you via?
❍Email: ❍Text: ❍ Carrier (like AT&T, Etc.): _____
Most patients are referred to our office by a caring family member or friend. What made you to decide to visit our office?
❍Friend ❍Family Member Name: _____
❍Telephone Call ❍Yelp ❍ Google Search ❍Website ❍Presentation ❍Email

Spinal problems can cause a variety of health problems. ***Please answer the following questions:***

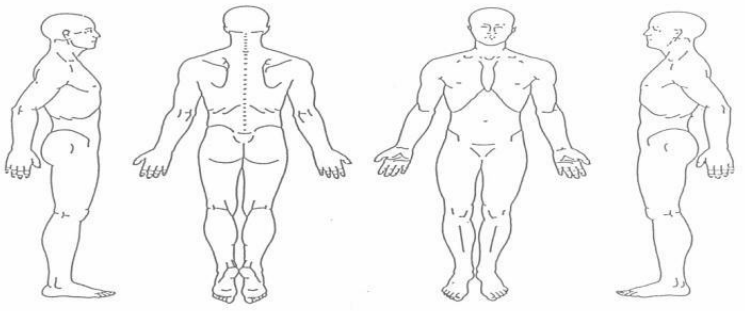
1. Please check the health complaint(s) you are currently experiencing or experience on a periodic basis:

❍ Low Back Pain	❍ Arm or Hand Pain	❍ Carpal Tunnel Syndrome	❍ Indigestion
❍ Upper/Mid Back Pain	❍ Leg or Foot Pain	❍ Ear Infections	❍ Chronic Fatigue
❍ Neck Pain	❍ Asthma	❍ Frequent Colds	❍ Arthritis
❍ Shoulder Pain	❍ Allergies/Sinus	❍ Spinal Curvature	❍ Fibromyalgia

❍ Others _____

2. Please list your primary health concern you are experiencing:
   1. _____ 2._____ 3._____
3. Auto and work injuries can cause serious spinal problems. Is this visit related to an auto or work injury? ❍ Yes ❍ No
4. Research shows that you spine should be checked regularly. When was your last complete Spinal examination ?
   ❍within the last year ❍ 1 - 5 years ❍ 5 years or longer ❍ Never
5. Have you ever been told that you have a spinal curvature, spinal arthritis, or inherited spinal problem?
   ❍ YES ❍ NO If yes circle which one
6. Long term spinal misalignments can cause decay and arthritis in the spine which may result in grinding or popping noises. Do you ever hear grinding or popping noises when you move your head or neck? ❍ YES ❍ NO
7. Spinal misalignments can make you feel like you need to twist, stretch or crack your neck or back. Do you ever feel the need to twist, stretch or crack your neck, mid or lower spine? ❍ YES ❍ NO
8. Poor posture can lead to poor health and usually indicates a spinal problem. How would you rate your posture?
   Poor - 1 2 3 4 5 6 7 8 9 10 - Very Good
9. Stress can cause or aggravate spinal problems. Please rate your stress levels over the last 90 days.
   Low - 1 2 3 4 5 6 7 8 9 10 - High
10. Are you currently taking prescription medication? ❍ YES ❍ NO If so, how many? _____
11. Spinal health is especially important during pregnancy. If female, is there any chance that you are pregnant?
    ❍ YES ❍ NO ❍ MAYBE If yes, when is your due date?_____ Or Date of Last Cycle? _____
12. Have you ever been diagnosed with cancer? ❍YES ❍NO If so, what kind?_____ Year diagnosed _____
13. Have you ever had spinal surgery? ❍ YES ❍ NO If yes, where?_____
14. If the doctor feels that you will benefit from chiropractic care, are you willing to follow his/her recommendations?
    ❍ YES ❍ NO
15. How will you be paying for today's visit? ❍ Credit/Debit Card ❍ Cash ❍ Check ❍ Other_____
16. Are you Medicare eligible? ❍ YES ❍ NO
17. What activities would you like to do that your health is impairing you to doing? _____
18. How would your life change if you have optimal health? _____
19. What needs to happen in order for you to have optimal health? _____
20. When did the symptoms appear? _____
21. Is the condition getting worse? _____
22. How often do you have this pain? _____

23. Is it constant or does it come and go? _____
24. Does it interfere with your ❍Work ❍Sleep ❍Recreation ❍Daily routine ❍ Other_____
25. Are the following painful or difficult? ❍ Sitting ❍Standing ❍ Walking ❍ Lying ❍ Bending ❍ Lifting ❍Other_____ _____
26. Where do you feel the pain:



Rate your pain 1-10 _____
Do you feel the following:
❍Numbness ❍Tingling ❍ Weakness ❍ Sharp ❍ Dull ❍ Ache ❍ Throbbing ❍ Burning ❍ Swelling ❍ Stiffness ❍ Cramps
How does your condition make you feel?
_____

27. What would you be able to do/enjoy that you can't currently if this condition was gone?
_____
28. Have you been treated for this condition previously? ❍ Yes ❍No
❍ Medication ❍ Surgery ❍ Chiropractic ❍Nutrition ❍Acupuncture ❍Other _____
29. Date of last exam: Physical _____Blood work _____ Urine _____X-Rays_____ MRI/CT/Ultrasound_____
30. **Have you had or have any on the following:**

Anemia ❍ Yes ❍ No	Alcoholism ❍ Yes ❍ No	Cancer ❍ Yes ❍ No
Arthritis ❍Yes ❍ No	Anorexia ❍Yes ❍ No	Bleeding disorder ❍ Yes ❍ No
Bronchitis ❍Yes ❍ No Cataracts ❍Yes ❍ No	High Blood pressure ❍Yes ❍No	Chemical Dependency ❍Yes ❍No
Chicken pox ❍Yes ❍ No	Bulimia ❍ Yes ❍No	Goiter ❍Yes ❍No
Diabetes ❍ Yes ❍ No	Emphysema ❍ Yes ❍No	Hepatitis ❍ Yes ❍ No
Epilepsy ❍Yes ❍ No	Glaucoma ❍Yes ❍ No	Herpes ❍ Yes ❍No
Gout ❍Yes ❍ No	Heart Disease ❍Yes ❍ No	Liver Disease ❍ Yes ❍ No
Hernia ❍Yes ❍ No	Herniated Disc ❍ Yes ❍No	Mumps ❍Yes ❍ No
High Cholesterol ❍Yes ❍No	Kidney Disease ❍ Yes ❍ No	Osteoporosis ❍ Yes ❍ No
Measles ❍Yes ❍ No	Miscarriage ❍ Yes ❍No	Tumors ❍ Yes ❍ No
Pacemaker ❍Yes ❍ No	Multiple Sclerosis ❍ Yes ❍ No	Psychiatric care ❍ Yes ❍No
Pneumonia ❍Yes ❍No	Parkinson's ❍Yes ❍No	**Do you get headaches? ❍Yes ❍No**
Prosthesis ❍Yes ❍ No	Prostate problem ❍Yes ❍No	**How often _____**
Rheumatoid Arthritis ❍Yes ❍No	Scarlet fever ❍Yes ❍No	**How would you describe them?**
Suicide attempt ❍Yes ❍No	Rheumatic fever ❍ Yes ❍No	❍ **Migraine** ❍ **Nausea**
Thyroid Problem ❍ Yes ❍ No	Tonsillitis ❍ Yes ❍ No	❍**Tension** ❍**Vomiting**
Typhoid fever ❍ Yes ❍ No	Tuberculosis ❍Yes ❍ No	❍**Related to allergies** ❍**Aura**
Venereal disease ❍ Yes ❍ No	Allergy shots ❍ Yes ❍ No	❍ **Light sensitive**
Vaginal infections ❍Yes ❍No	Appendicitis ❍ Yes ❍ No	❍ **Related to allergies**
Ulcers ❍ Yes ❍ N	Autoimmune ❍Yes ❍ No	❍**Ocular migraine**
Whooping cough ❍ Yes ❍ No	Breast lump ❍Yes ❍No	❍**Visual disturbance**

Other: _____

31. Are you pregnant? ❍ Yes ❍No Due Date_____ 32. Have you ever take antibiotics? ❍Yes ❍ No When_____
34. Are you taking birth control ❍Yes ❍ No 35. Have you used hormone replacement therapy ❍Yes ❍ No
36. Are you Vegetarian ❍ Yes ❍No 37. Do you skip meals ❍Yes ❍ No 38. Do you crave sugar ❍Yes ❍No

Description Date Description Date

Injuries/Surgeries _____ Broken Bones_____
Falls_____ Auto Accidents_____
Head injuries_____ Surgeries_____

The above information is true and accurate to the best of my knowledge. Copies of any X-rays and reports will be released upon written request, however original X-rays remain the property of the clinic.

Signature:_____Date _____