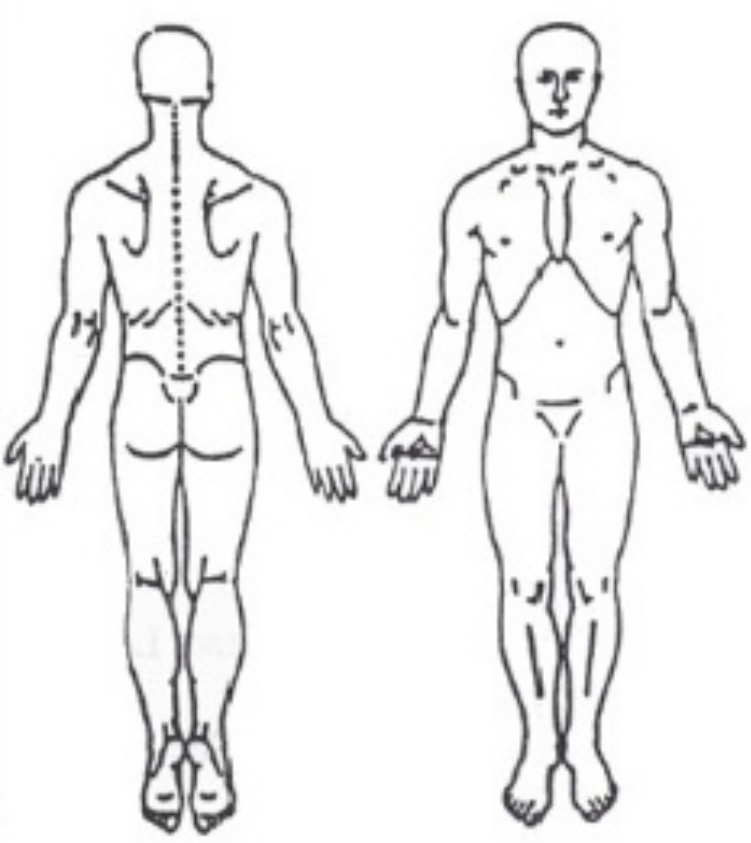
Dr Suzanne Murphy at Vitality Spa & Wellness
NEW PATIENT HISTORY

NAME _____DATE_____HOME PHONE_____WORK_____
ADDRESS_____CITY _____ STATE ____ ZIP _____ CELL _____
DOB_____AGE ____ MARITAL STATUS_____ NAME/AGES OF CHILDREN _____
OCCUPATION_____EMPLOYER_____SSN_____
EMPLOYER ADDRESS_____CITY_____STATE_____ZIP_____
NAME OF SPOUSE (parent if minor)_____OCCUPATION_____EMPLOYER_____
EMERGENCY CONTACT_____PHONE_____M.D._____
EMAIL_____WHO MAY WE THANK FOR REFERRING YOU?_____
PREFERRED NAME (how you would like to be addressed)_____

REASON FOR VISIT

THE REASON FOR THIS VISIT IS A RESULT OF (please circle) AUTO WORK FALL SPORTS CHRONIC OTHER WELLNESS SPINAL CHECK
PLEASE DESCRIBE YOUR MAJOR COMPLAINT AND HOW IT HAPPENED_____
_____



DATE STARTED___/___/___HAD BEFORE?_____
PLEASE DESCRIBE_____
_____
_____
_____

IS THIS INTERFERING WITH YOUR (please circle)
WORK SLEEP DAILY ROUTINE
SPORTS RECREATION OTHER
IF SO, PLEASE EXPLAIN_____
_____
_____
_____

IN THE AREAS TO THE LEFT. PLEASE INDICATE WHERE YOU ARE EXPERIENCING PAIN OR SYMPTOMS BY DRAWING IN THE LETTER ABBREVIATIONS ON THE DIAGRAMS

SHARP PAIN = P DULL PAIN = D
STIFFNESS = S NUMBNESS = N
TINGLING = T BURNING = B

PLEASE LIST EACH AREA OF YOUR SYMPTOMS IN ORDER OF SEVERITY, AND THEN AT THE SCALE TO THE RIGHT, MARK AN (X) THAT BEST REPRESENTS THE LEVEL OF SEVERITY.

AREA OF SYMPTOM	NO PAIN OR SYMPTOMS	**SEVERITY**	WORST PAIN IMAGINABLE
_____	_____		
_____	_____		
_____	_____		

HEALTH HISTORY

HAVE YOU HAD	YES	NO	DATE	PLEASE DESCRIBE
MEDICAL CARE FOR THIS	___	___	____	_____
SURGERIES/FRACTURES	___	___	____	_____
MEDICATIONS?	___	___	____	_____

DIABETES? _____ CANCER?_____ AUTO IMMUNE?_____ HEART DISAEASE? _____ OTHER_____

FAMILY HISTORY OF HEALTH ___ ___ ____ _____

DO YOU HAVE ANY DIFFICULTY WITH THE FOLLOWING:

IF YOU HAVE THE CONDITION NOW, PLACE AN "N" IN THE SPACE; IF IN THE PAST, PLACE A "P".

___ABDOMINAL	___COLDS/INFECTIONS	___ GALL BLADDER	___MENTAL DISEASE	___SINUS TROUBLE
___ALCOHOLISM	___COLON TROUBLE	___ GOUT	___NAUSEA	___SLEEPLESSNESS
___ALLERGY	___CONSTIPATION	___GYNECOLOGICAL	___NERVOUSNESS	___STRESS
___ANEMIA	___DEPRESSION	___PNEUMONIA	___STROKE	___THYROID
___ARTHRITIS	___DIABETES	___HEARING TROUBLE	___POOR APPETITE	___ULCERS
___ASTHMA	___DIZZINESS	___HEART DISEASE	___PROSTATE	___VARICOSE VEINS
___CANCER	___EPILEPSY	___HEADACHES	___SCIATICA	___VISION PROBLEMS
___CHEST PAIN	___FATIGUE	___HEMORRHOIDS	___SHORT OF BREATH	
___COLD HANDS/FEET	___WEIGHT GAIN/LOSS	___HARDENING OF ARTERIES		

LIST ANY CONDITIONS, TESTS, OR EXAMS IN THE LAST 10 YEARS WE SHOULD KNOW ABOUT. _____

_____

_____

FOR FEMALES: ARE YOU PREGNANT?_____DO YOU TAKE BIRTH CONTROL PILLS?_____

HEALTH HABBITS

ALCOHOL_____ /WK TOBACCO_____PACKS/DAY EXERCISE_____ WORK_____HRS/DAY

COFFEE_____CUPS/DAY DRUGS_____ SLEEP_____HRS/NIGHT VITAMINS_____

PERSONAL GOALS

1. WHAT ARE YOUR FAVORITE HOBBIES TO DO NOW? _____

2. HOW ARE YOUR CURRENT PROBLEMS AFFECTING THESE ACTIVITIES OR HOBBIES? _____

3. Any other goals or health conditions you would like to address? _____

WEIGHT_____ AMBULATION_____ BALANCE _____ POSTURE_____

PERFORMANCE_____DIET_____NUTRITION_____

OTHER_____

ON A SCALE OF 0-10 (0 BEING THE LEAST AND 10 BEING THE MOST)

_____HOW COMMITTED ARE YOU BEING AT YOUR MAXIMUM HEALTH POTENTIAL? IF NOT 8-10, PLEASE EXPLAIN. ____

_____

IF YOU HAVE PREVIOUSLY SEEN A CHIROPRACTOR, PLEASE DESCRIBE YOUR LIKES AND DISLIKES (IF ANY), SO WE MAY BETTER SERVE YOU. _____

_____

_____

PATIENTS SIGNATURE (OR PARENT'S, IF MINOR) _____DATE_____