

Weis Chiropractic Health Center
CONFIDENTIAL New PATIENT INFORMATION FORM
10671 McSwain Drive
Cincinnati, OH 45241
Voice: 513.563.0414 FAX 513.563.9540 Web: www.weischiro.com

Instructions

The information on this document is kept in your confidential patient file in our office as a record of your office visit.

After printing the document, please fill it out completely. Bring the completed and signed document with you to your office visit. By doing so you'll be able to speed up the initial registration process as a new patient.

New Patient Symptom Assessment
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Patient Full Name: _____

DOB: _____ Date: _____

Do you suspect you may be pregnant? Yes No

Do you have chest pain? Yes No

Do you have any unusual bleeding or discharge? Yes No

Do you have a nagging cough or hoarseness? Yes No

Do you have headaches for hours or days? Yes No

Do you have blurred vision? Yes No

Do you have pain in your jaw or face? Yes No

Do you have dizziness? Yes No

Do you suffer from slurred speech? Yes No

Do you have mid-back pain? Yes No

Do you have shortness of breath? Yes No

Do you fatigue easily? Yes No

Do you suffer from depression? Yes No

Does your pain ever wake you from a sound sleep? Yes No

Are you losing weight without trying? Yes No

Are you coughing up blood or noticing it in your urine or stool? Yes No

Do you smoke? Yes No If yes, how long? _____ How many packs per day? _____

Do you drink alcohol? Yes No If yes, how much? _____

Are you allergic to any foods or drugs? Yes No

If yes, what? _____

Substance abuse? Yes No

What prescription medication(s) are you currently taking, if any?

() High blood pressure medication () Muscle Relaxers

() Anti-inflammatory medication () Blood thinners

() Pain Medication () Birth control pills

() Other

What over the counter medication(s) have you been taking?

New Patient Symptom Assessment
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List any of your past surgical procedures, if any, and the date in which they were performed.

List any past injuries, if any, and the date in which they occurred.

Are you seeing another doctor for any other reason? Yes No Comments:

Did you, your mother or your father have any of the following? (Circle **M** for mother, **F** for father, **S** for self):

High blood pressure	M	F	S
Heart Attack	M	F	S
Emphysema	M	F	S
Seizures-Convulsions	M	F	S
HIV Positive	M	F	S
Asthma	M	F	S
Diabetes	M	F	S
Kidney disease	M	F	S
Ulcer or stomach problems	M	F	S
Stroke	M	F	S
Arthritis-Rheumatism	M	F	S
Mental illness	M	F	S
Thyroid disease	M	F	S
Circulation problems	M	F	S
Cancer	M	F	S

Patient Signature