**New Patient Form**

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| Name Date |
| Address |
| Town State ZIP |
| Home Phone Cell Phone |
| Birth Date Sex M F |
| Emergency Contact Ph. # |
| Email Referred By |
| Employer Medicare? y/n |
| **Symptoms-** Primary Complaint: |
| How did it develop?  When was the first time you had this condition?  How many times have you had this condition? |
| Rate your pain: 1 2 3 4 5 6 7 8 9 10 Is it getting worse? |
| Other type of treatment tried? |
| **Health History** Circle all that apply |
| AIDS/HIV Gout Parkinson’s Diabetes Neck pain  Allergies Liver disease Stroke Ear Infections Mid back pain  Anemia Hernia Tuberculosis Insomnia Low back pain  Asthma Herniated Disc Ulcers Heart murmur Hip pain L/R  Eating Disorder Herpes Hypertension Neuropathy Wrist pain L/R  Cancer High Cholesterol Metal Implants Dizziness Shoulder pain L/R  Eye problems Migraines Bleeding disorder Leg cramps Knee pain L/R  Depression M.S. Thyroid condition Leg/Arm numbness/pain/weakness  Fractures Mononucleosis Fibromyalgia Headaches Ankle pain L/R  Goiter Pacemaker Chronic Fatigue Gastrointestinal Prob. Other  Are you pregnant? |
| Height: Weight: BP per pt:  Surgeries/Hospitalizations:  Medications: |
| How much do you smoke per day? Alcohol per week? |
| Has this condition interfered with your ability to dress, shower, drive a car or sleep?  with you r hobbies, sports or fitness?  with your productivity at work or school?  with your ability to care for your family/ spouse? |
| Patient Signature: Date: |

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