**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 painAllergies Liver disease Stroke Ear Infections Mid back painAnemia Hernia Tuberculosis Insomnia Low back painAsthma Herniated Disc Ulcers Heart murmur Hip pain L/REating Disorder Herpes Hypertension Neuropathy Wrist pain L/RCancer High Cholesterol Metal Implants Dizziness Shoulder pain L/REye problems Migraines Bleeding disorder Leg cramps Knee pain L/RDepression M.S. Thyroid condition Leg/Arm numbness/pain/weakness Fractures Mononucleosis Fibromyalgia Headaches Ankle pain L/RGoiter Pacemaker Chronic Fatigue Gastrointestinal Prob. OtherAre 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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