

New Patient Health Analysis

(770) 368-0333

Rick Neal, DC

Peachtree Corners Chiropractic Clinic

Number: _____

Date: _____

Patient: _____

Home Phone: _____

Age: _____

Marital Status: Single Married Widowed Separated Divorced

Occupation: _____

Insurance Carrier: _____

Address: _____

City: _____

State: _____

Zip: _____

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| 1. Do you need glasses to read? | Yes | No |
| 2. Do you need glasses to see things at a distance? | Yes | No |
| 3. Has your eyesight often blacked out completely? | Yes | No |
| 4. Do your eyes continually blink or water? | Yes | No |
| 5. Do you often have bad pains in your eyes? | Yes | No |
| 6. Are your eyes often red or inflamed? | Yes | No |
| 7. Are you hard of hearing? | Yes | No |
| 8. Have you ever had a fluid leaking from your ear? | Yes | No |
| 9. Do you have constant noises in your ears? | Yes | No |
| 10. Do you have to clear your throat constantly? | Yes | No |
| 11. Do you often feel a choking lump in your throat? | Yes | No |
| 12. Are you often troubled with bad spells of sneezing? | Yes | No |
| 13. Is your nose constantly stuffed up? | Yes | No |
| 14. Do you suffer from a constantly running nose? | Yes | No |
| 15. Have you at times had bad nose bleeds? | Yes | No |
| 16. Do you often catch severe colds? | Yes | No |
| 17. Do you frequently suffer from heavy chest colds? | Yes | No |
| 18. When you catch a cold, do you always have to go to bed? | Yes | No |
| 19. Do frequent colds keep you miserable all winter? | Yes | No |
| 20. Do you get hay fever? | Yes | No |
| 21. Do you suffer from asthma? | Yes | No |
| 22. Are you troubled by constant coughing? | Yes | No |
| 23. Have you ever coughed up blood? | Yes | No |
| 24. Do you wake up drenched with sweat in the middle of the night? | Yes | No |
| 25. Have you ever had a chronic chest condition? | Yes | No |
| 26. Have you ever had TB (tuberculosis)? | Yes | No |
| 27. Did you ever live with anyone who had TB? | Yes | No |

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| 28. Has a doctor ever said your blood pressure was too high? | Yes | No |
| 29. Has a doctor ever said your blood pressure was too low? | Yes | No |
| 30. Do you have pains in the heart or chest? | Yes | No |
| 31. Are you often bothered by thumping of the heart? | Yes | No |
| 32. Does your heart often race like mad? | Yes | No |
| 33. Do you often have difficulty breathing? | Yes | No |
| 34. Do you get out of breath before anyone else? | Yes | No |
| 35. Do you sometimes get out of breath just sitting still? | Yes | No |
| 36. Are your ankles often badly swollen? | Yes | No |
| 37. Do cold hands or feet trouble you, even in hot weather? | Yes | No |
| 38. Do you suffer from frequent cramps in your legs? | Yes | No |
| 39. Has a doctor ever said you had heart trouble? | Yes | No |
| 40. Does heart trouble run in your family? | Yes | No |

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| 41. Are your joints often painfully swollen? | Yes | No |
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| 42. Do your muscles and joints constantly feel stiff? | Yes | No |
| 43. Do you usually have severe pains in the arms or legs? | Yes | No |
| 44. Are you crippled with severe arthritis? | Yes | No |
| 45. Does arthritis run in your family? | Yes | No |
| 46. Do weak or painful feet make your life miserable? | Yes | No |
| 47. Do pains in the back make it hard for you to keep up with your work? | Yes | No |
| 48. Are you troubled with a serious bodily disability or deformity? | Yes | No |
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| 49. Do you suffer from frequent severe headaches? | Yes | No |
| 50. Does pressure or pain in the head often make life miserable? | Yes | No |
| 51. Are headaches common in your family? | Yes | No |
| 52. Do you have hot or cold spells? | Yes | No |
| 53. Do you often have spells of severe dizziness? | Yes | No |
| 54. Do you frequently feel faint? | Yes | No |
| 55. Have you fainted more than twice in your life? | Yes | No |
| 56. Do you have constant numbness or tingling in any part of your body? | Yes | No |
| 57. Was any part of your body ever paralyzed? | Yes | No |
| 58. Were you ever knocked unconscious? | Yes | No |
| 59. Have you ever had a twitching of the head face or shoulders? | Yes | No |
| 60. Did you ever have a seizure or convulsion (epilepsy)? | Yes | No |
| 61. Has anyone in your family ever had seizures or convulsion (epilepsy)? | Yes | No |
| 62. Do you bite your nails? | Yes | No |
| 63. Are you troubled by stuttering or stammering? | Yes | No |
| 64. Are you a sleep walker? | Yes | No |
| 65. Are you a bed wetter? | Yes | No |
| 66. Were you a bed wetter between the ages of 8 to 14? | Yes | No |
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| 67. Do you have to get up every night and urinate? | Yes | No |
| 68. During the day, do you have to urinate frequently? | Yes | No |
| 69. Do you often have severe burning when you urinate? | Yes | No |
| 70. Do you sometimes lose control of your bladder? | Yes | No |
| 71. Has a doctor ever said you had kidney or bladder disease? | Yes | No |
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| 72. Are you often exhausted or fatigued? | Yes | No |
| 73. Does working tire you out completely? | Yes | No |
| 74. Do you usually get up tired or exhausted in the morning? | Yes | No |
| 75. Does every little effort wear you out? | Yes | No |
| 76. Are you constantly too tired and exhausted to even eat? | Yes | No |
| 77. Do you suffer from severe nervous exhaustion? | Yes | No |
| 78. Does nervous exhaustion run in your family? | Yes | No |
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| 79. Are you frequently ill? | Yes | No |
| 80. Are you frequently confined to bed by illness? | Yes | No |
| 81. Are you always in poor health? | Yes | No |
| 82. Are you considered a sickly person? | Yes | No |
| 83. Do you come from a sickly family? | Yes | No |
| 84. Do severe pains and aches make it impossible for you to do your work? | Yes | No |
| 85. Do you wear yourself out worrying about work? | Yes | No |
| 86. Are you always ill and unhappy? | Yes | No |
| 87. Are you constantly made miserable by poor health? | Yes | No |