Austin Sport and Chiropractic

NEW PATIENT ENTRY

Name	Age
Spouse	Birthday
Referred By	Phone
Occupation	E-Mail
Address	
Are you currently enrolled in Medicare or Medicaid? Yes / No	

Below for Office Use Only
O P Q R S T
O P Q R S T
O P Q R S T

Motor (0-5) □ WNL	L	R
Resisted neck ROM (C1-C4)		
Shoulder elevation (CN XI, C3-C6)		
Shoulder abduction (C4-C6)		
Elbow flexion (C5-C6)		
Elbow extension (C6-C8)		
Wrist/finger flexion (C7-T1)		
Wrist/finger extension (C6-C8)		
Hip flexion (L1-L3)		
Knee extension (L2-L4)		
Knee flexion (L4-S1)		
Plantar flexion (L5-S2)		
Dorsiflexion (L4-L5)		
Other:		

Cervical	L	R
Flexion (45)		
Extension (55)		
Lateral Flex (45)		
Rotation (70)		

Lumbar	L	R
Flexion (90)		
Extension (30)		
Lateral Flex (20)		
Rotation (30)		

Cervical	L	R
Maximal Comp		
Soto Hall		
Distraction		

Lumbar	L	R
SLR		
Patricks		
SI Comp		

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NEW PATIENT ENTRY

Nervous System
- ☐ Nervous/Anxiety
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion / Depression
- ☐ Fainting
- ☐ Convulsions / Seizures
- ☐ Shooting Pain

Musculo-Skeletal
- ☐ Neck Pain
- ☐ Low Back Pain
- ☐ Upper Back Pain
- ☐ Arm Pain
- ☐ Leg Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ TMJ
- ☐ General Stiffness

General
- ☐ Fatigue
- ☐ Allergies / Asthma
- ☐ Poor Sleep
- ☐ Fever
- ☐ Headaches
- ☐ Fibromyalgia

C-V-R
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems
- ☐ Stroke
- ☐ Cold Extremities

EENT
- ☐ Vision Problems
- ☐ Sore Throat
- ☐ Ringing in Ears
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

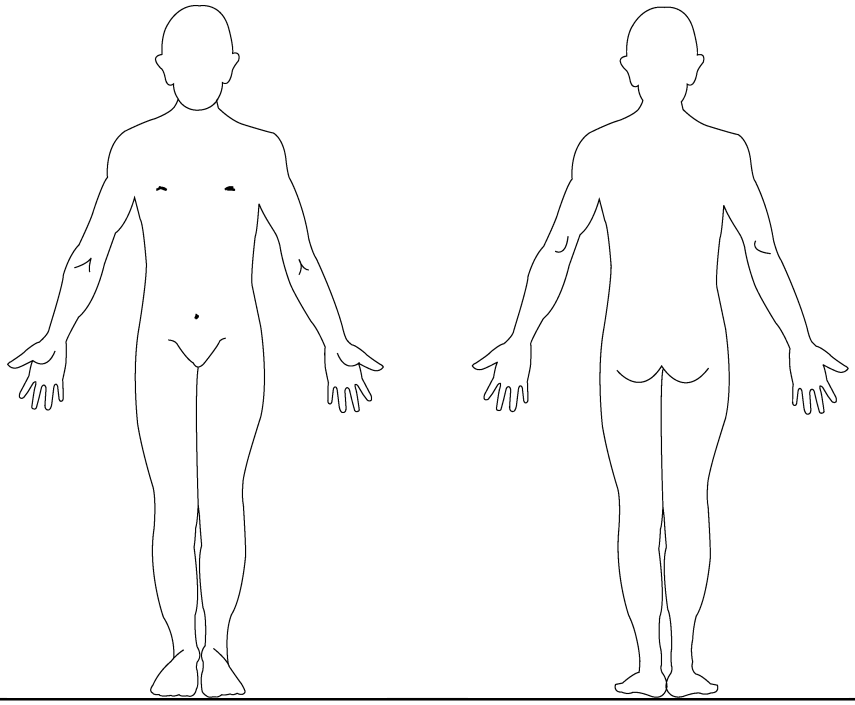
Gastro-Intestinal
- ☐ Poor / Excessive Appetite
- ☐ Poor / Excessive Thirst
- ☐ Frequent Nausea
- ☐ Diarrhea / Constipation
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Heartburn / Acid Reflux
- ☐ Diabetes
- ☐ Black/Bloody Stool

Mark the areas on your body where you feel:

Numbness
OOOOOO

Stabbing
/ / / / / / / / /

Ache
XXXXXXX



Neck-Arm-Pain
I rate my discomfort as follows:
(_____)
0 10
no pain severe pain

Mid Back Pain
I rate my discomfort as follows:
(_____)
0 10
no pain severe pain

Low Back and Leg Pain
I rate my discomfort as follows:
(_____)
0 10
no pain severe pain

Sign_____Date_____

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NEW PATIENT ENTRY

Name_____Date_____

List all current MAJOR health conditions.	List all treatments for these conditions.
1)_____ 2)_____ 3)_____ 4)_____ 5)_____ 6)_____	1)_____ 2)_____ 3)_____ 4)_____ 5)_____ 6)_____

List any surgeries and associated dates.

_____
_____

List all current medications not mentioned above and frequency of use.

_____
_____

List all traumas, motor vehicle accidents, broken bones and associated dates.

_____
_____

Have you ever been to a chiropractor before? If so, please describe your experience.

_____

What type of results do you hope to achieve for from chiropractic care?

_____
_____