

New Patient Information Form
Dr. Clop

Name: _____ Today's Date: _____
 Height _____ Weight: _____ Sex: M F Date of Birth: _____
 Referring Doctor: _____ Age: _____ R L Handed

1. Which best describes the reason for your visit today. List location on line (e.g. low back, hand neck leg, etc.)
 (Place number e.g. #1, #2 in order of severity)
 Pain _____ Numbness _____ Tingling _____
 Weakness _____ Spinal Deformity _____ Other _____
 (Scoliosis)
- 1a. Any bowel or bladder symptoms _____
2. When did this problem begin? _____
3. Did it begin spontaneously or was there a specific injury? (Circle one) (If injury, please describe)

4. Have you had prior similar symptoms in the past? Y N
 If Yes:
 Date of most recent _____ Date of initial episode _____
5. Rate your pain: (Circle one) No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain
6. Has your condition improved, deteriorated or remained the same since the episode began?
7. What makes your symptoms worse (Circle all that apply)
 Sitting Standing Bending Forward Walking Going Up/Down Stairs None of the above
 Other _____
8. What treatment have you received so far: (Circle all that apply)
 Physical therapy Anti-inflammatories Chiropractic care
 Oral steroids Epidural steroid injections Muscle relaxants
 Surgery Pain medications Other _____
9. Is your pain worse when you are trying to sleep compared to the pain during the day? Y N
10. Have you personally had cancer of any type? Y N

Medication	Dose	Reason for Medication
Allergies:		

Past Medical History

Surgeries/Hospitalizations	Year

Have you ever had problems with anesthesia? No Yes
 If yes, describe _____

Have you ever had problems with your:

	Circle	Describe all yes responses
Eyes	Yes No	_____
Ears, nose, throat	Yes No	_____
Digestive problem	Yes No	_____
Bladder or prostate problem	Yes No	_____
Diabetes	Yes No	_____
High blood pressure	Yes No	_____
Heart disease	Yes No	_____
High cholesterol	Yes No	_____
Kidney disease	Yes No	_____
Bleeding problems	Yes No	_____
Hepatitis or liver disease	Yes No	_____
Depression	Yes No	_____
Cancer	Yes No	_____
Arthritis	Yes No	_____
Lungs or breathing problems	Yes No	_____
Seizures or neurologic disease	Yes No	_____
Gastritis / Ulcers	Yes No	_____

Family History

Significant family history: (Cancer, osteoporosis . . .) _____

Social History

Employed (occupation: _____) Student Retired

Single Married Divorced Widowed

Children? No Yes# _____

Exercise? Daily Weekly Rarely

What type of exercise? _____

History of substance abuse? No Yes What type? _____

Smoke currently? No Yes If yes, _____ packs per day for _____ years.

Quit smoking? No This year > 5 years > 10 years

Alcohol consumption? Never Daily 1-2 times per week Rarely

Patient Signature: _____ **Date:** _____

Reviewed By: _____ **MD** **Date:** _____