

# chiropractic

Bringing Out The Best In You!

Linda Dirlam D.C.  
Natural Healing Center of Iowa  
401 Main Street, Suite 216  
Cedar Falls, Iowa 50613  
319-277-5437  
www.NHCIowa.com

New Patient Welcome To Our Office

Date \_\_\_\_\_

Name \_\_\_\_\_ Preferred name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone #s (home) \_\_\_\_\_ (cell) \_\_\_\_\_

Email address \_\_\_\_\_

SS # \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Is it okay to contact you at work?  no  yes Work # \_\_\_\_\_

Marital status  single  married  separated  divorced  widowed

Spouse's name \_\_\_\_\_ Phone #(s) \_\_\_\_\_

Children's names and ages \_\_\_\_\_

Do you have any pets?  no  yes If yes, please tell us what kind(s) \_\_\_\_\_

Favorite hobbies or interests \_\_\_\_\_

Emergency contact: Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone #(s) \_\_\_\_\_

## What Brings You Here?

Have you ever had chiropractic care before?  no  yes

If yes, please tell us who \_\_\_\_\_ Phone # \_\_\_\_\_

Were you pleased with your care?  no  yes

How did you find out about our office? \_\_\_\_\_

Is this appointment related to  work  sports  auto  
 personal injury  other \_\_\_\_\_

When did the incident occur? \_\_\_\_\_

Attorney (if applicable) \_\_\_\_\_ Phone # \_\_\_\_\_

Are you receiving care from other health professionals?  no  yes

If yes, please name them and their specialty \_\_\_\_\_

Please list any drugs or medications you are taking \_\_\_\_\_

Please list any vitamins/herbs/homeopathics/other you are taking \_\_\_\_\_

Are you pregnant?  no  yes If yes, what month? \_\_\_\_\_

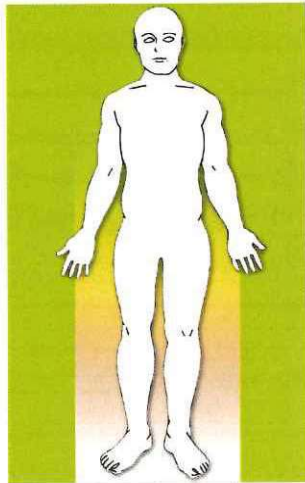
### Current Health

What are your pressing health concerns? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

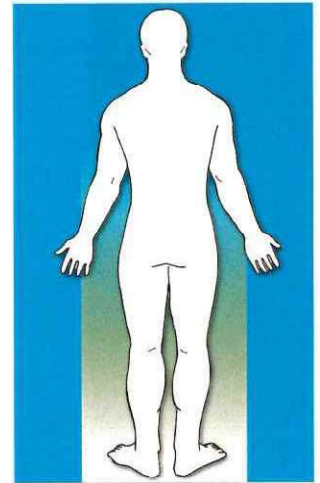
For how long? \_\_\_\_\_

Is it  getting worse  improving  intermittent  constant  can't say

Where is the problem? Please use the illustrations and lines below to explain.



Front \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Back \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Do you have  pain  numbness  tingling  aches
- Is your pain  sharp  dull  throbbing  constant  intermittent
- Are your symptoms affected by  sitting  standing  walking
- bending  lying down  weather  other

Please explain \_\_\_\_\_  
\_\_\_\_\_

- Do you feel  cramps  burning  stiffness  swelling  other

Please explain \_\_\_\_\_  
\_\_\_\_\_

- Do your symptoms interfere with  work  sleep  day-to-day activities
- play  other \_\_\_\_\_

Please explain \_\_\_\_\_  
\_\_\_\_\_

**On a scale of 1-10 (1 least, 10 most), please rate:**

The severity of your symptoms 1 2 3 4 5 6 7 8 9 10





## Health History

Do you have, or have you had, any of the following (please check  all that apply)?

- |                                    |                                  |                                     |  |                                   |
|------------------------------------|----------------------------------|-------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> pneumonia | <input type="checkbox"/> mumps   | <input type="checkbox"/> influenza  | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> smallpox |
| <input type="checkbox"/> pleurisy  | <input type="checkbox"/> polio   | <input type="checkbox"/> chickenpox | <input type="checkbox"/> thyroid disease | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> epilepsy  | <input type="checkbox"/> cancer  | <input type="checkbox"/> depression | <input type="checkbox"/> whooping cough  | <input type="checkbox"/> anemia   |
| <input type="checkbox"/> eczema    | <input type="checkbox"/> measles | <input type="checkbox"/> arthritis  | <input type="checkbox"/> heart disease   | <input type="checkbox"/> rashes   |
| <input type="checkbox"/> colitis   | <input type="checkbox"/> stroke  | <input type="checkbox"/> allergies  | _____                                    |                                   |

If you have ever been diagnosed with another disease or condition, please describe \_\_\_\_\_

Do you drink  coffee  tea  alcohol

Do you use  cigarettes  recreational drugs  artificial sweeteners  sugar

Have you ever suffered from (please check  all that apply)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> neck pain               | <input type="checkbox"/> difficulty breathing | <input type="checkbox"/> discolored urine         |
| <input type="checkbox"/> low back pain           | <input type="checkbox"/> stuffy nose          | <input type="checkbox"/> gas/bloating after meals |
| <input type="checkbox"/> headache                | <input type="checkbox"/> fainting             | <input type="checkbox"/> heartburn                |
| <input type="checkbox"/> migraines               | <input type="checkbox"/> weight loss          | <input type="checkbox"/> irritable bowel          |
| <input type="checkbox"/> arm pain/tingling       | <input type="checkbox"/> poor appetite        | <input type="checkbox"/> black or bloody stools   |
| <input type="checkbox"/> shoulder pain           | <input type="checkbox"/> excessive appetite   | <input type="checkbox"/> constipation             |
| <input type="checkbox"/> hand pain/tingling      | <input type="checkbox"/> nervousness          | <input type="checkbox"/> hemorrhoids              |
| <input type="checkbox"/> leg pain/tingling       | <input type="checkbox"/> confusion            | <input type="checkbox"/> liver problems           |
| <input type="checkbox"/> jaw pain                | <input type="checkbox"/> depression           | <input type="checkbox"/> paralysis                |
| <input type="checkbox"/> chest pain              | <input type="checkbox"/> dental problems      | <input type="checkbox"/> numbness                 |
| <input type="checkbox"/> lung problems           | <input type="checkbox"/> excessive thirst     | <input type="checkbox"/> fatigue                  |
| <input type="checkbox"/> heart problems          | <input type="checkbox"/> frequent nausea      | <input type="checkbox"/> dizziness                |
| <input type="checkbox"/> abnormal blood pressure | <input type="checkbox"/> prostate problem     | <input type="checkbox"/> loss of sleep            |
| <input type="checkbox"/> irregular heartbeat     | <input type="checkbox"/> breast pain/lump     | <input type="checkbox"/> difficulty hearing       |
| <input type="checkbox"/> ankle swelling          | <input type="checkbox"/> cramps               | <input type="checkbox"/> ear pain                 |
| <input type="checkbox"/> cold extremities        | <input type="checkbox"/> painful urination    | <input type="checkbox"/> other _____              |
| <input type="checkbox"/> blurred vision          | <input type="checkbox"/> bladder trouble      | _____   |
| <input type="checkbox"/> vision problems         | <input type="checkbox"/> excessive urination  | _____   |

If applicable, date of last menstrual period \_\_\_\_\_

Past injuries can affect present health (please check  all that apply)

- |  |  |  |                                  |
|--|--|--|----------------------------------|
| <input type="checkbox"/> falls/accidents         | <input type="checkbox"/> head injuries         | <input type="checkbox"/> fights              | <input type="checkbox"/> surgery |
| <input type="checkbox"/> sports injuries         | <input type="checkbox"/> broken bones          | <input type="checkbox"/> dislocations        | <input type="checkbox"/> other   |
| <input type="checkbox"/> spinal tap              | <input type="checkbox"/> knocked unconscious   | <input type="checkbox"/> traction            | _____                            |
| <input type="checkbox"/> use(d) a cane or walker | <input type="checkbox"/> extensive dental work | <input type="checkbox"/> dental applications | _____                            |

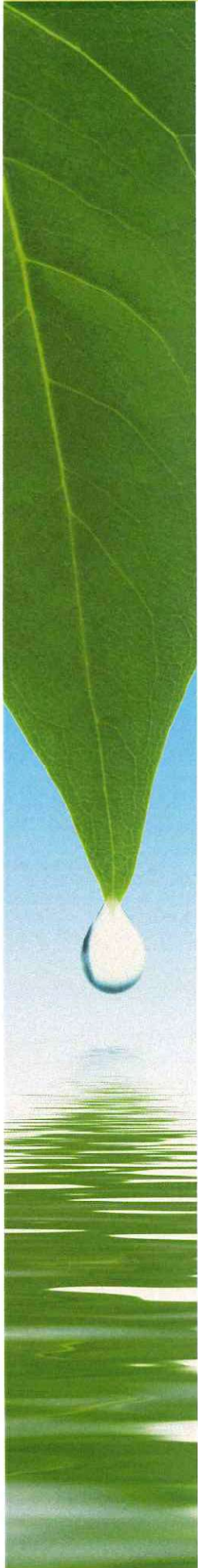
If yes to any of the above, please describe \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



### What Do You Know About Chiropractic?

In your own words, what do chiropractors do? \_\_\_\_\_

Do you know what a subluxation is?  no  yes

If yes, please describe \_\_\_\_\_

Do any friends or relatives see chiropractors:  no  yes

If yes, do they use chiropractic for  health maintenance/optimization  
 health problems  both

Are you seeking chiropractic for  health maintenance/optimization  
 health problems  both

What would you like to gain from chiropractic care? \_\_\_\_\_

Are there other health concerns or anything else you'd like us to know about you?  no  yes

If yes, please tell us \_\_\_\_\_

### Financial Responsibility

Who is responsible for payment? \_\_\_\_\_

How will you pay for your care?  Cash  Check  Credit Card

Credit card # \_\_\_\_\_ Exp. \_\_\_\_\_

Insurance co. \_\_\_\_\_ Phone # \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

Subscribers's name \_\_\_\_\_ Phone # \_\_\_\_\_

Relation \_\_\_\_\_ Subscriber's employer \_\_\_\_\_

Subscribers's SS # \_\_\_\_\_ Subscriber's birthdate \_\_\_\_\_

The above is accurate to the best of my knowledge.

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)

I, parent/guardian, give permission for minor's care.

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)

