NEW PATIENT INFORMATION

NAME_____ HOME PHONE_____ CELL PHONE_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

SSN_____ DL#_____ BIRTHDAY_____ AGE____ MALE_____ FEMALE_____

MARITAL STATUS: SINGLE / MARRIED / DIVORCED / WIDOWED NUMBER OF CHILDREN_____

OCCUPATION:_____ EMPLOYER:_____

EMPLOYER'S ADDRESS:_____

NAME OF SPOUSE:_____ EMPLOYER:_____ PHONE:_____

NEAREST RELATIVE:_____ PHONE:_____

EMAIL ADDRESS:_____

HOW DID YOU FIRST HEAR OF GGC?

PHONEBOOK_____ TV_____ NEWSPAPER_____ BILLBOARD_____ FRIEND_____ OTHER_____

WHO CAN WE THANK FOR REFERRING YOU TO US:_____

LIST YOUR CHIEF COMPLAINTS IN ORDER OF SEVERITY:

1)_____ FOR HOW LONG?_____

2)_____ FOR HOW LONG?_____

3)_____ FOR HOW LONG?_____

4)_____ FOR HOW LONG?_____

WHO IS YOUR CURRENT MEDICAL DOCTOR?_____

CHECK THE SYMPTOMS THAT MAY APPLY:

___HEADACHE
___NECK PAIN
___NECK STIFFNESS
___SLEEPING PROBLEMS
___NERVOUSNESS
___TENSION
___NUMBNESS IN FINGERS
___CONSTIPATION
___LOSS OF BALANCE
___FEET COLD

___IRRITABILITY
___CHEST PAIN
___DIZZINESS
___HEAD SEEMS HEAVY
___PINS & NEEDLES IN ARMS
___PINS & NEEDLES IN LEGS
___NUMBNESS IN TOES
___DIARRHEA
___LOSS OF TASTE
___HANDS COLD

___SHORTNESS OF BREATH
___FATIGUE
___DEPRESSION
___LIGHTS BOTHER EYES
___LOSS OF MEMORY
___FAINTING
___EARS RINGING/BUZZING
___STOMACH UPSET
___LOSS OF SMELL
___COLD SWEATS

IS THIS INJURY RELATED TO AN AUTOMOBILE ACCIDENT?_____

WHEN DID YOUR SYMPTOMS FIRST START?_____

HOW FREQUENT IS THE PAIN?_____

HOW DID THIS HAPPEN?_____

DESCRIBE THE PAIN:_____

WHAT MAKES IT WORSE:_____

WHAT MAKES IT BETTER:_____

IS IT WORSE IN THE MORNING OR EVENING?_____

DOES IT RADIATE TO ANY OTHER PARTS OF YOUR BODY?_____

HOW DOES THIS AFFECT YOU AT HOME/WORK?_____

WHAT MEDICATIONS ARE YOU TAKING RIGHT NOW?_____

HAVE YOU HAD ANY FALLS OR ACCIDENTS? (PLEASE DESCRIBE):_____

_____

HAVE YOU HAD ANY PRIOR TREATMENT FOR THIS OR SIMILAR CONDITION?_____

IF SO, WHAT AND WHERE?_____

HAVE YOU EVER BEEN INVOLVED IN AN AUTO ACCIDENT? (PLEASE DESCRIBE)_____

_____

IF FEMALE, ARE YOU PREGNANT?_____DATE OF LAST MENSTRUAL PERIOD?_____

LIST SURGERIES YOU HAVE HAD AND THE YEAR THEY WERE PERFORMED:_____

_____

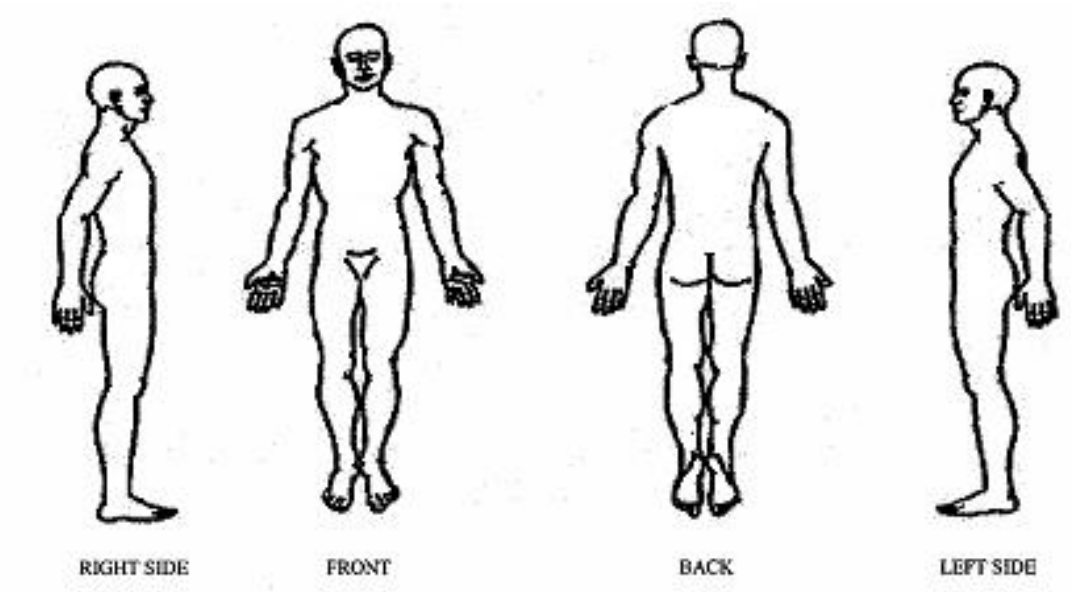
_____

HAVE YOU EVER BEEN DIAGNOSED WITH CANCER?_____

ANY UNUSUAL DISEASES?_____

Please mark the areas of all of your complaints on the diagrams to the right.

N = numbness
T = tingling
P = pain
W = weakness



SIGNATURE:_____ DATE:_____