Dry Creek Chiropractic
3300 N Running Creek Way
Bldg. E Ste. 100
Lehi, UT 84043
Phone 801-766-4113
Fax 801-766-4776

New Patient Form

Date _____

First Name _____ Last Name _____

Nickname _____

DOB _____ Birth Sex: ◯ Male ◯Female SSN _____

Email _____

Address _____ City_____

State _____ Zip _____

Phone 1 _____ Phone 2 _____

◯Home ◯Mobile ◯Work ◯Other ◯Home ◯Mobile ◯Work ◯Other

Job Status: ◯Not Employed ◯Employed ◯Retired ◯Student

Marital Status: ◯Single ◯Married ◯Other _____

Are you Pregnant? ◯Yes ◯No

Reason for Visit _____

How Heard of Us:

◯Social Media ◯Google ◯Website ◯Referral Referred by _____

Appointment Reminders: ◯Decline ◯Voice ◯Text ◯Email

Message Contact: ◯Decline ◯Voice ◯Text ◯Email

Demographics

Race:

⬜Declines to Specify

⬜White

⬜Asian

⬜Black or African American

⬜American Indian or Alaska Native

⬜Hawaiian or Pacific Islander

⬜Other

Ethnicity:

◯Declines to Specify

◯Hispanic or Latino

◯Not Hispanic or Latino

Hand Dominance:

◯Right

◯Left

◯Ambidextrous

Gender Identity:

◯Male

◯Female

◯Non-binary

Previous Name: _____
(for insurance purposes)

Emergency Contact

First Name _____ Last Name _____

Phone 1 _____ Phone 2 _____

Relationship _____

Employment Info

(Workers Compensation Only)

Employer _____ Employer Phone _____

Occupation _____

Primary Care Provider _____

Insurance

(If you have given us your insurance card, don't fill this out)

Primary Insurance

Insured First Name _____ Insured Last Name _____

DOB _____ Relationship to Insured ◯Self ◯Spouse ◯Child ◯Other

Insurance Name _____ Insurance Phone _____

ID# _____ Group# _____

Renewal Date_____

Secondary Insurance

Insured First Name _____ Insured Last Name _____

DOB _____ Relationship to Insured ◯Self ◯Spouse ◯Child ◯Other

Insurance Name _____ Insurance Phone _____

ID# _____ Group# _____

Renewal Date_____

MIST

Medications/Vitamins/Supplements:

Medication_____ Dose_____ Frequency_____ Start Date_____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Allergies:

Allergy_____ Severity_____ Onset_____

◯Side effect ◯Intolerance ◯Reaction

Allergy_____ Severity_____ Onset_____

◯Side effect ◯Intolerance ◯Reaction

NOTES:

Past and Present Illnesses/Disorders:

Illness/Disorder_____ Onset_____ End Date_____

◯Current ◯Resolved ◯Inactive

Illness/Disorder_____ Onset_____ End Date_____

◯Current ◯Resolved ◯Inactive

Illness/Disorder_____ Onset_____ End Date_____

◯Current ◯Resolved ◯Inactive

Surgeries:

Surgery _____ Date _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Traumas:

Trauma_____ Date_____

◯Current ◯Resolved ◯Inactive

Trauma_____ Date_____

◯Current ◯Resolved ◯Inactive

Trauma_____ Date_____

◯Current ◯Resolved ◯Inactive

Daily Habits

Do you smoke? ⬜Never smoked ⬜Current smoker ⬜Former smoker

If yes, how many packs per day?_____

If yes, how many years have you smoked?_____

Daily caffeinated beverages:

⬜Unknown ⬜None ⬜1-3 ⬜4-6 ⬜7-10 ⬜11-15 ⬜over 15

Weekly alcoholic beverages:

⬜Unknown ⬜None ⬜1-3 ⬜4-6 ⬜7-10 ⬜11-15 ⬜over15

Do you exercise regularly? ⬜No ⬜Light ⬜Moderate ⬜Heavy

What is your stress level? ⬜None ⬜Low ⬜Moderate ⬜Severe

What is your sleep like?

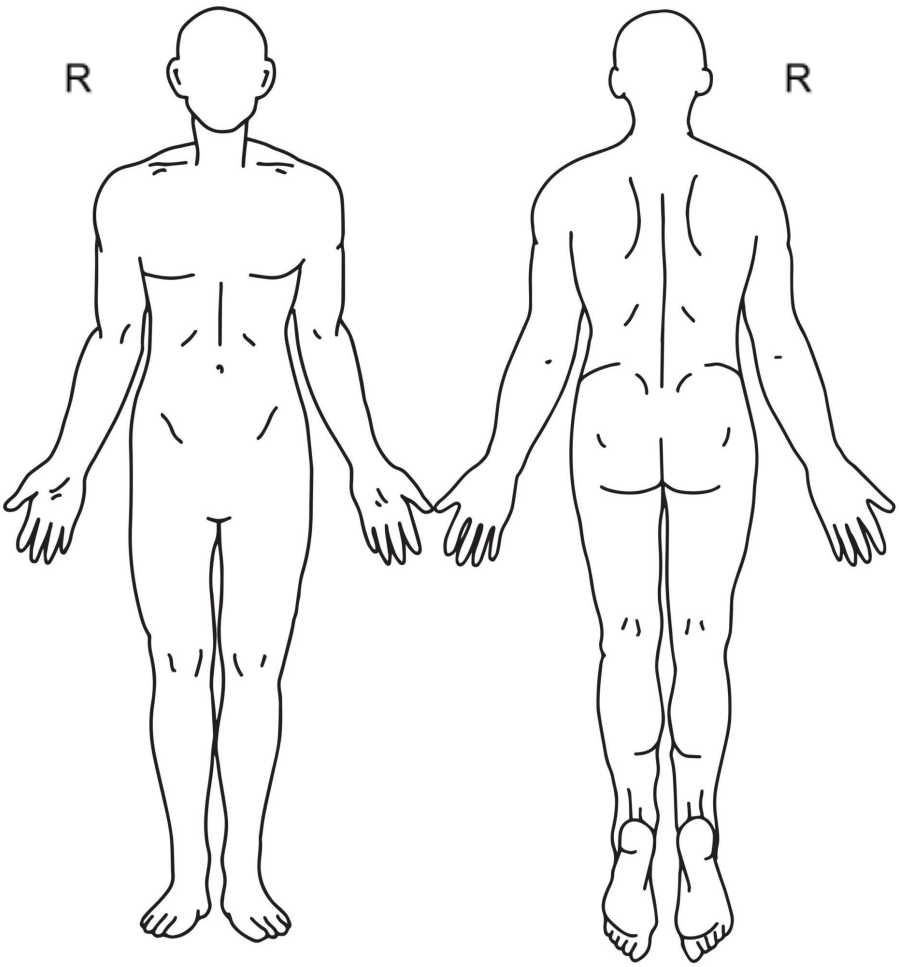
⬜Restful ⬜Trouble Falling asleep ⬜Trouble staying asleep ⬜Other:_____

Energy Level: ⬜Good ⬜Insufficient ⬜Erratic

Complaint

Chief complaint: What is your main complaint? _____

Location: Please circle the area(s) where you experience symptoms.



Frequency: How often do you experience pain?

- ⬜Occasional (1-25%)
- ⬜Intermittent (26-50%)
- ⬜Frequent (51-75%)
- ⬜Constant (75-100%)

Onset: When did the symptoms start? _____

Cause: Do you know what caused the problem?_____

Compared to when it began, is your condition:

⬜Same ⬜Better ⬜Worse

Intensity: On a scale of 1-10, what is your pain level today?

1 2 3 4 5 6 7 8 9 10

Quality: Describe your pain

⬜aching ⬜burning ⬜cramping ⬜deep ⬜dull ⬜numb ⬜radiating ⬜sharp

⬜shooting ⬜sore ⬜stabbing ⬜stiff ⬜swelling ⬜tight ⬜tingling ⬜throbbing

⬜other:_____

Aggravating Factors: What makes the problem worse?

⬜most movements ⬜bending ⬜carrying things ⬜eating ⬜exercise ⬜heat

⬜housework ⬜lying to sitting ⬜sitting to standing ⬜ice ⬜lying down ⬜massage

⬜sitting ⬜standing ⬜stretching ⬜deep breathing ⬜twisting ⬜walking

⬜other:_____

Does the pain travel anywhere else? ⬜Yes ⬜No If yes, where?_____

Relieving Factors: What makes the problem better?

⬜nothing ⬜anti-inflammatories ⬜bracing ⬜chiropractic care ⬜elevation ⬜exercise

⬜heat ⬜ice ⬜massage ⬜movement ⬜painkillers ⬜rest ⬜stretching ⬜walking

⬜wraps ⬜other:_____

What daily activities are affected due to the problem?

⬜caring for children ⬜driving ⬜eating ⬜exercising ⬜hygeine ⬜housework ⬜lifting

⬜sex ⬜sleeping ⬜social/recreational activities ⬜toileting ⬜using technology ⬜walking

⬜working ⬜other:_____

Have you been given a diagnosis for the problem? ⬜Yes ⬜No

If yes, what was the diagnosis?_____

What treatments have you tried for your condition?

⬜None ⬜Medication ⬜Surgery ⬜Physical therapy ⬜Chiropractic ⬜Massage Therapy

⬜Other:_____

Review of Systems

Other than your current complaint, what concerns have you experienced in the following systems?

Musculoskeletal: ⬜Never ⬜Previously ⬜Currently ⬜I don't know

If yes, please specify:_____

Cardiovascular/Respiratory: ⬜Never ⬜Previously ⬜Currently ⬜I don't know

If yes, please specify:_____

Head/Neck: ⬜Never ⬜Previously ⬜Currently ⬜I don't know

If yes, please specify:_____

Eyes: ⬜Never ⬜Previously ⬜Currently ⬜I don't know

If yes, please specify:_____

Nose: ⬜Never ⬜Previously ⬜Currently ⬜I don't know

If yes, please specify:_____

Ears: ⬜Never ⬜Previously ⬜Currently ⬜I don't know

If yes, please specify:_____

Throat/Mouth: ⬜Never ⬜Previously ⬜Currently ⬜I don't know

If yes, please specify:_____

Urinary: ⬜Never ⬜Previously ⬜Currently ⬜I don't know

If yes, please specify:_____

Gastrointestinal: ⬜Never ⬜Previously ⬜Currently ⬜I don't know

If yes, please specify:_____

Endocrine: ⬜Never ⬜Previously ⬜Currently ⬜I don't know

If yes, please specify:_____

Vascular/Hematologic: ⬜Never ⬜Previously ⬜Currently ⬜I don't know

If yes, please specify:_____

Neurologic: ⬜Never ⬜Previously ⬜Currently ⬜I don't know

If yes, please specify:_____

Psychiatric: ⬜Never ⬜Previously ⬜Currently ⬜I don't know

If yes, please specify:_____

Genitourinary or Reproductive: ⬜Never ⬜Previously ⬜Currently ⬜I don't know

If yes, please specify:_____