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 _____-_____-_____

Address _____ City_____ State _____ Zip _____

Phone 1 _____ Phone 2 _____ Email _____
◯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:
- ◯Male
- ◯Female

Previous Name: _____
(for insurance purposes

Emergency Contact

First Name _____ Last Name _____ Relationship _____
Phone 1 _____ Phone 2 _____

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

_____ _____ _____ ◯Side effect ◯Intolerance ◯Reaction

_____ _____ _____ ◯Side effect ◯Intolerance ◯Reaction

Past and Present Illnesses/Disorders:

Illness/Disorder_____ Onset_____ End Date_____ ◯Current ◯Resolved ◯Inactive

_____ _____ _____ ◯Current ◯Resolved ◯Inactive

_____ _____ _____ ◯Current ◯Resolved ◯Inactive

Surgeries:

Surgery_____ Date _____

_____ _____

_____ _____

Traumas:

Trauma_____ Date_____ ◯Current ◯Resolved ◯Inactive

_____ _____ ◯Current ◯Resolved ◯Inactive

_____ _____ ◯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

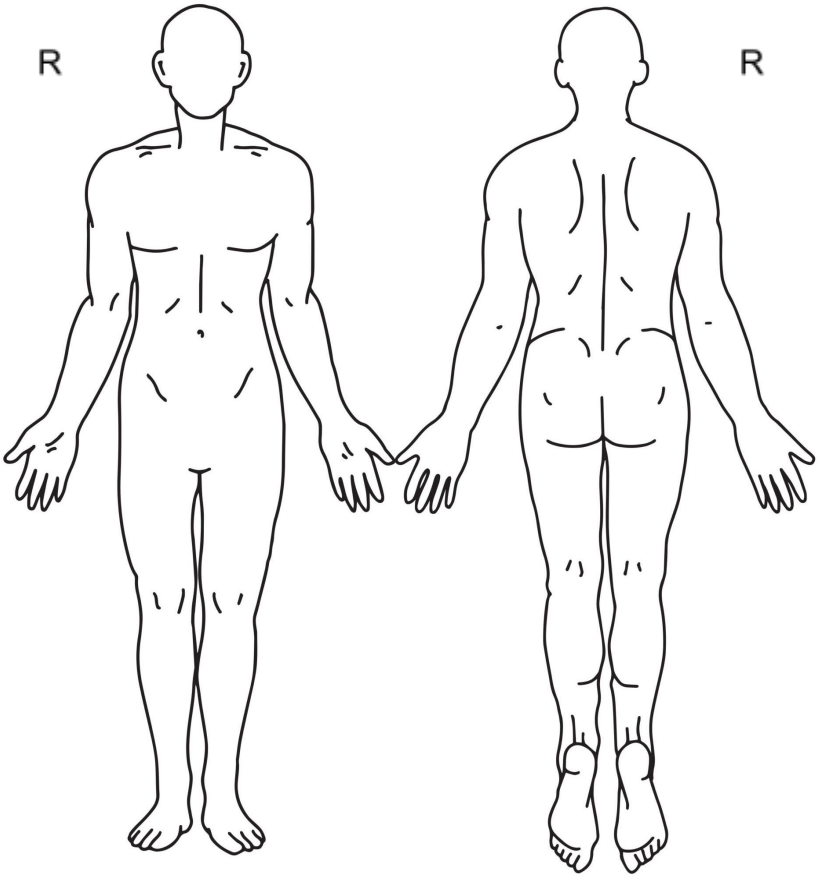
What is your sleep like? ☐Restful ☐Trouble Falling asleep ☐Trouble staying asleep ☐Other:_____

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? (Circle one)

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 ⬜ eating ⬜ exercise
⬜ heat ⬜ housework ⬜ carrying things ⬜ lying down
⬜ lying to sitting ⬜ sitting to standing ⬜ ice ⬜ 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 t**herapy ⬜ 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:_____