New Patient History

(Please Print)

Dr. Nicholas Saviano, D.C.

Name: _____ Email: _____Cell Phone: _____

Address: _____City: _____ Zip: _____ Hm Phone: _____

Birth Date: _____ ☐ Male ☐ Female Spouse's Name: _____

Children #_____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed Driver's License # _____

Occupation:_____Employer: _____ Wk Phone: _____

Social Security# : _____ How were you referred to the Office? _____

Have you been under chiropractic care? _____ If yes,Dr's Name:_____ when? _____

List your chief concerns in order of severity: Check all those that describe your condition:

Concern 1: _____ For how long? _____

Is this the result of a car accident? ☐yes ☐no OR work injury ☐yes ☐no, if yes, date of injury _____

Is it getting ☐worse or ☐staying the same? Other Dr.'s Consulted:_____

☐ Sharp ☐ Throbbing ☐ Shooting ☐ Cramps ☐ Stiffness ☐ Dull Ache ☐ Numb/Tingling ☐Burning

☐Other: _____ 0------1------2-------3-------4-------5-------6-------7-------8-------9-------10

☐ Constant (100%) ☐ Frequent (50% - 90%) ☐ Intermittent (25% - 50%) ☐ Occasional (1% - 25%)

Concern 2: _____ For how long? _____

Is this the result of a car accident? ☐yes ☐no OR work injury ☐yes ☐no, if yes, date of injury _____

Is it getting ☐worse or ☐staying the same? Other Dr.'s Consulted:_____

☐ Sharp ☐ Throbbing ☐ Shooting ☐ Cramps ☐ Stiffness ☐ Dull Ache ☐ Numb/Tingling ☐Burning

☐Other: _____ 0------1------2-------3-------4-------5-------6-------7-------8-------9-------10

☐ Constant (100%) ☐ Frequent (50% - 90%) ☐ Intermittent (25% - 50%) ☐ Occasional (1% - 25%)

Concern 3: _____ For how long? _____

Is this the result of a car accident? ☐yes ☐no OR work injury ☐yes ☐no, if yes, date of injury _____

Is it getting ☐worse or ☐staying the same? Other Dr.'s Consulted:_____

☐ Sharp ☐ Throbbing ☐ Shooting ☐ Cramps ☐ Stiffness ☐ Dull Ache ☐ Numb/Tingling ☐Burning

☐Other: _____ 0------1------2-------3-------4-------5-------6-------7-------8-------9-------10

☐ Constant (100%) ☐ Frequent (50% - 90%) ☐ Intermittent (25% - 50%) ☐ Occasional (1% - 25%)

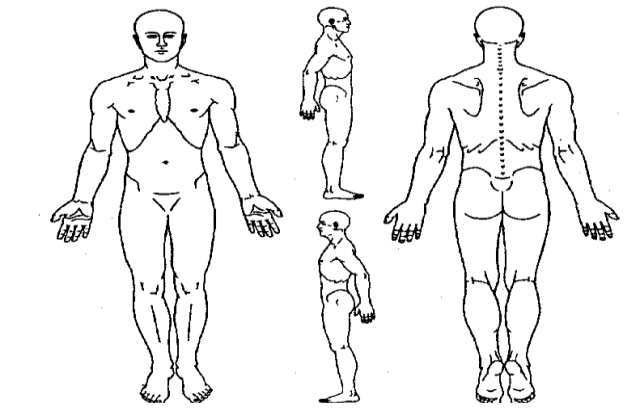
Health Insurance:_____MemberID_____

Insured's Name (f different): _____ Insured's date of birth: _____

Are you covered by any other health insurance: ☐ yes ☐ no _____

Please provide us with a copy of your insurance ID card

Mark an "X" on the areas you feel pain. Draw an arrow if the pain travels.
Include all affected areas



Please list any medications you are taking:

_____
_____
_____

Please list any previous surgeries/hospitalizations:

_____
_____
_____

Height:_____ Weight:_____

These questions are designed to measure the degree to which your pain/discomfort now affects your ability to function in everyday activities. For each of the categories of life activity, please circle the number that best describes the level of how you feel when performing the activities listed. A score of 0 indicates no pain/discomfort when performing the activity. A score of 10 indicates you are unable to perform this activity due to the pain/discomfort.

Does your pain/discomfort interfere with your normal work inside and/or outside the home?
Work Normally 0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10 Unable to work at all.

Does your pain/discomfort interfere with personal care (i.e. washing, dressing, etc.)?
Care for self completely 0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10 Need help for personal care

Does your pain/discomfort affect your ability to sit or stand?
No problems0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10 Cannot sit/ stand at all

Does your pain/discomfort interfere your ability to lift overhead, grasp objects or reach for things?
No problem 0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10 Cannot do at all

Does your pain/discomfort interfere your ability to lift objects off the floor, bend, stoop or squat?
No problem 0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10 Cannot do at all

Does your pain/discomfort interfere your ability to walk or run?
No problem 0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10 Cannot do at all

Does your pain/discomfort interfere recreational activities and hobbies that are important to you?
No interference 0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10 Total interference

Do you have to take pain medication every day to control your pain?
No medication needed 0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10 Pain meds. throughout day

Do you need help from family/friends to complete everyday tasks (in or out of home) because of your pain/discomfort?
Never need help 0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10 Need help all the time

Does your pain/discomfort interfere with your ability to sleep?
No problem 0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10 Severe problems.

Does your pain/discomfort interfere with the frequency /quality of your sex life?
No problem 0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10 Severe problems.

Are there emotional problems caused by your pain/discomfort that interfere with your family, social or work activities?
No problem 0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10 Severe problems.

Women Only: This is to certify that to the best of my knowledge I am not pregnant, & Wittwer Chiropractic Center & it's associates have my permission to perform an x-ray evaluation. I have been advised that x-rays are hazardous to an unborn child.
Date of last menstrual period. _____ Signature_____ Date_____

Notice: Not all patients require x-rays to determine or verify a diagnosis, type, and length of care. If your examination warrants x-ray analysis, the following office policy prevails: All first-visit charges are to be paid when services are rendered. The fee paid for x-rays is for analysis only. The film itself is the property of this office and cannot be released.

I have read the above information & certify it to be true & correct to the best of my knowledge. I clearly understand & agree that all services rendered are ultimately my responsibility for payment.

Patient's Signature: _____ Date: _____