**DEMETREE CHIROPRACTIC GROUP**

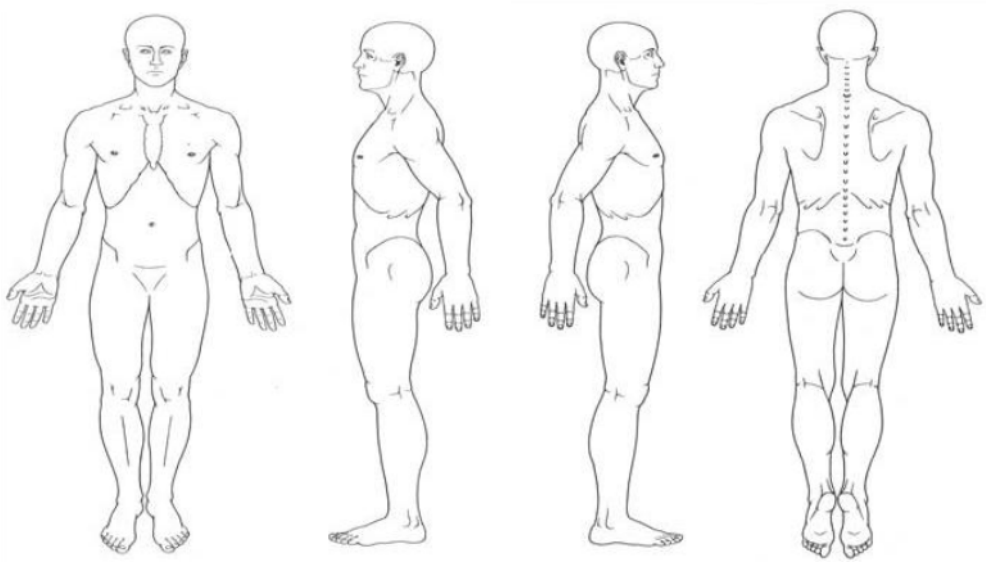
**MATTHEW C. DEMETREE, D.C.**
**DEMETREE CHIROPRACTIC GROUP**
3505 S. ORLANDO DRIVE
SANFORD, FL 32773
(407) 324-8222

# New Patient Medical History Form

NAME:_____AGE:_____DATE:_____

Date of Symptom:_____Right or Left Handed?_____

Please mark on picture where you have or have had pain or other symptoms:
Include symptoms of pain, numbness or tingling:



Are you having pain, numbness or tingling now?_____

Where?_____

Mark a circle around <u>what hurts the most</u>.

Are your symptoms: Staying the same now_____ Improving_____Getting worse_____

Does your pain increase or get better with activity?_____

What makes it better?_____

What makes it worse?_____

Is today a: Good day_____ Average Day_____ Bad Day_____

Is your pain constant?_____ or intermittent?_____

Rate your pain <u>NOW</u> (Circle One)

NONE – 0 MILD – 1-2-3 MODERATE – 4-5-6-7 SEVERE – 8-9-10



Patient Initials _____

**D**EMETREE
**C**HIROPRACTIC
**G**ROUP

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# New Patient Medical History Form – Page 2

NAME_____ DATE_____

**Current Medications**:_____
_____

**Medical History: (Circle if you have or had any of the following)**

TB Diabetes Cancer High Blood Pressure Fracture Migraines

Venereal Disease Back Pain Arm Pain Leg Pain Other_____

**Please Circle if you have ever seen any of the following:**

Chiropractor Osteopath Neurologist Neurosurgeon Orthopaedist

**List any injuries you have had include falls, auto accidents, sports or work injuries:**_____
_____

**Surgical History:** List all surgeries you have had:
_____
_____

**Female History:** Date of Last Menstrual Cycle_____

Regular? Yes No Is there a chance you might be pregnant?_____

Birth Control? Yes No Breast Lumps?_____

**Social History:** Smoke_____ Drink_____ Exercise_____

**SIGNATURE_____DATE_____**



Patient Initials _____