Dr. Trevor O. Eriksen, B.A., D.C.
4600 Kietzke Lane, Bldg E, Suite 145 *Reno, NV 89502* *(775) 772-7961*

New Patient Form

Patient Information

Date _____
Patient Name _____
Address _____
_____
City *State* *Zip*
Sex M ❑ F ❑ Age _____ Birthdate _____
Height _____ Weight _____
Single ❑ Married ❑ Widowed ❑ Separated ❑ Partner ❑
Patient SS# _____
Occupation _____
Referral from _____
_____

Phone Numbers

Home _____ Work _____ Ext _____
Best time and place to reach you _____

In Case of Emergency Contact

Name _____ Relationship _____
Home Phone _____
Work Phone _____ Ext _____

Accident Information

Is condition due to an accident? Yes ❑ No ❑
Type of accident Auto ❑ Work ❑ Home ❑ Other ❑
Injury Date _____ Time ____ Work Related? Yes ❑ No ❑
X-rays taken since injury? Yes ❑ No ❑

Patient Condition

Reason for Visit
When did your symptoms appear? Is this condition worsening? Yes ❑ No ❑
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)

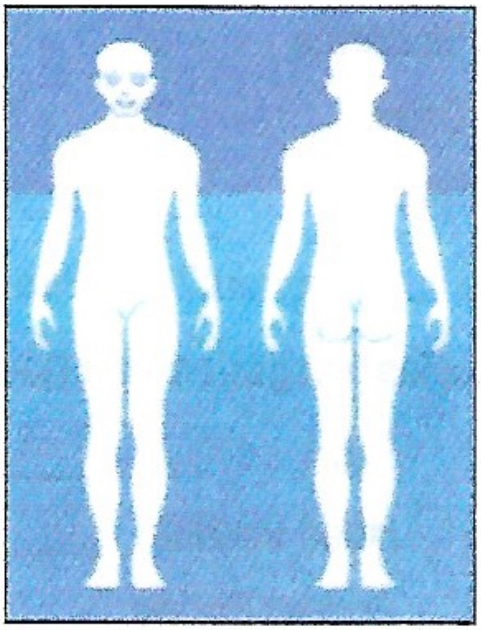
Area of Complaint

❑ Headaches	❑ Hip	❑ Shoulder
❑ Neck Pain	❑ Knee	❑ Chest
❑ Mid Back	❑ Ankle	❑ Ribs
❑ Low Back	❑ Foot	❑ Elbow
❑ Sacroiliac	❑ Wrist	

Type of Pain

❑ Sharp	❑ Dull	❑ Throbbing
❑ Numbness	❑ Aching	❑ Shooting
❑ Burning	❑ Tingling	❑ Cramps
❑ Stiffness	❑ Swelling	❑ Other

How often do you have this pain?
Is it constant or does it come and go?
Does it interfere with your:
❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation
Activities or movements that are painful to perform:
❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down



Place an X on the area of pain

I hereby assign payment directly to this office for professional services rendered and I shall be personally responsible for any unpaid balance to the doctor.

Insured Signature _____ **Date** _____

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New Patient Form (page 2)

Health History Patient Name _____

What treatment have you already received for your condition? ❑ Medications ❑ Surgery ❑ Physical Therapy ❑ Chiropractic Services ❑ None ❑ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

_____

Date of last Physical Exam _____ Spinal X-Ray _____ Blood Test _____
Spinal Exam _____ Chest X-Ray _____ Urine Test _____
Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place an X on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV ❑ Yes ❑ No	Emphysema ❑ Yes ❑ No	Alcoholism ❑ Yes ❑ No	Epilepsy ❑ Yes ❑ No
Stroke ❑ Yes ❑ No	Fractures ❑ Yes ❑ No	Anemia ❑ Yes ❑ No	Multiple Sclerosis ❑ Yes ❑ No
Glaucoma ❑ Yes ❑ No	Anorexia ❑ Yes ❑ No	Osteoporosis ❑ Yes ❑ No	Thyroid Problems ❑ Yes ❑ No
Gonorrhea ❑ Yes ❑ No	Pacemaker ❑ Yes ❑ No	Arthritis ❑ Yes ❑ No	Parkinson's Disease ❑ Yes ❑ No
Gout ❑ Yes ❑ No	Asthma ❑ Yes ❑ No	Hepatitis ❑ Yes ❑ No	Heart Disease ❑ Yes ❑ No
Herpes ❑ Yes ❑ No	Cancer ❑ Yes ❑ No	Diabetes ❑ Yes ❑ No	Pinched Nerve ❑ Yes ❑ No
Prosthesis ❑ Yes ❑ No	Kidney Disease ❑ Yes ❑ No	Liver Disease ❑ Yes ❑ No	Tumors,Growths ❑ Yes ❑ No
Chicken Pox ❑ Yes ❑ No	Prostrate Problem ❑ Yes ❑ No	Psychiatric Care ❑ Yes ❑ No	Chemical Dependency ❑ Yes ❑ No
Migraine Headaches ❑ Yes ❑ No	Breast Lump ❑ Yes ❑ No	Herniated Disk ❑ Yes ❑ No	Other _____

Exercise
❑ None
❑ Moderate
❑ Daily
❑ Heavy

Work Activity
❑ Sitting
❑ Standing
❑ Light Labor
❑ Heavy Labor

Habits
❑ Smoking Packs/Day _____
❑ Alcohol Drinks/Week _____
❑ Coffee/Caffeine Drinks Cups/Day _____
❑ High Stress Level Reason _____

Are you pregnant ❑ Yes ❑ No Due Date _____

Injuries/Surgeries you have had	**Description**	**Date**
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications **Allergies** **Vitamins/Herbs/Minerals**