Wunderlich Chiropractic Clinic, P.A.

Dr. Chance Wunderlich

1402 Lafayette Street – Cape Coral, FL, 33904 - (239) 540-9888
www.drwunderchiro.com

NEW PATIENT INFORMATION FORM

FIRST NAME: _____ LAST NAME: _____ MI: ____ DATE: _____

What symptoms brings you into our office today? _____

When did your symptoms begin? _____

(*Please circle the correct answer below*)

Do you feel your condition is:	**Improving**	**Staying**	**Worsening**	
Have you lost time from work?		**Yes**	**No**	
Can you perform physical work activities?		**Yes**	**No**	
If no, because of:	**Pain**		**Weakness**	**Stress**
Does your condition cause sleeping problems?		**Yes**	**No**	
Do you awaken because of pain?		**Yes**	**No**	
Did you have sleeping problems before?		**Yes**	**No**	

Activities of Daily Living

Please select all activities with which you are currently experiencing problems:

Seeing	**Tasting**	**Smelling**	**Eating**	**Hearing**	**Insomnia**
Dressing	**Reading**	**Typing**	**Writing**	**Grasping**	**Restful Sleeping**
Standing	**Leaning**	**Walking**	**Stooping**	**Squatting**	**Loss of Concentration**
Bending	**Twisting**	**Carrying**	**Lifting**	**Pushing**	**Changes in personality**
Sitting	**Driving**	**Sports**	**Exercising**	**Reclining**	**Tactile Feeling**
Riding in Car	**Air Travel**	**Climbing**	**Pulling**	**Bathing**	**Holding**
Grooming	**Bathing**	**Kneeling**	**Reaching**		

Past Medical History

Please select all conditions that you have had or are currently having:

Anorexia	**Anxiety**	**Aortic Aneurysm**	**Arthritis**	**Angina**	**Asthma**
Bladder Inf.	**Blood Disorder**	**Breast Soreness**	**Bronchitis**	**Cancer**	**Heart Attack**
Chest Pain	**Chronic Cough**	**Chronic Sinusitis**	**Colitis**	**COPD**	**Constipation**
Convulsions	**Dermatitis**	**Diabetes**	**Depression**	**Dizziness**	**Emphysema**
Epilepsy	**Fainting**	**Fatigue**	**Gout**	**Hand Pain**	**Headache**
Heart Attack	**Heart Disease**	**High Cholesterol**	**High Blood Pressure**		**Heartburn**
Hepatitis	**Hypertension**	**Jaw Pain**	**Kidney Disorder/Stones**		**Loss of Appetite**
Low Back Pain	**Mid Back Pain**	**Neck Pain**	**Liver/Gallbladder problems**		**Lung Disease**
Osteoarthritis	**Leg Pain**	**Knee Pain**	**Ankle Pain**	**Hip Pain**	**Shoulder Pain**
Elbow Pain	**Wrist Pain**	**Muscle Pain**	**Swelling/Stiffness of Joints**		**Scoliosis**
Tuberculosis	**Stroke**	**Thyroid Disease**	**Prostate Problems**		**Rapid Heart**
None	**Other:_____**				

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Family History

MOTHER	**Alive**	**Deceased**	**FATHER**	**Alive**	**Deceased**
Current Age (if still living)		**_____**	**Current Age (if still living)**		**_____**
Age at death		**_____**	**Age at death**		**_____**
Cause of death		**_____**	**Cause of death**		**_____**
Illnesses		**_____**	**Illnesses**		**_____**

PLEASE LIST ALL NOTEABLE CONDITIONS THAT RUN IN YOUR IMMEDIATE FAMILY:

1.

2.

3.

Surgical History

Please list all notable surgeries that you've had in the past:

Surgery	Date	Surgery	Date

Social History

Please circle the correct answer to the following questions:

Do you currently consume **Tobacco** **Alcohol** **Coffee**

Do you currently exercise? **Yes** **How Often: _____** **No**

Do you currently use a walker, cane or wheelchair? **Yes** **No**

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