Evan Rush, D.C.
2755 N. Wickham Rd. Suite 104
Melbourne, FL 32935

NEW PATIENT INFORMATION

Today's Date _____

Name _____ Age _____ Date of Birth_____

Address _____

City _____ State _____ ZIP _____

Height_____ Weight (Approx)_____

Cell Phone _____ Email_____

Occupation_____ Employer _____

Emergency Contact: Name _____ Phone _____

How did you find out about us? _____

Have you ever been to a Chiropractor before? _____

How long ago was your last visit? _____

Who is your family physician? _____

Was this injury due to an auto accident? Yes ☐ No ☐ Date:_____

Was this an on-the-job injury? Yes ☐ No ☐ Date:_____

Have you had any treatment for this problem in the past? Yes ☐ No ☐

If so, by whom and when? _____

Have you had any x-rays, MRI, CT or other imaging studies in the past 5 years? Yes☐ No☐

If so, what type of imaging study and when?_____

Where? _____

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HEALTH HISTORY

Do you currently have any of the following?	
Neck Pain	o Yes o No
Midback Pain	o Yes o No
Lower Back Pain	o Yes o No
Arm or Hand Pain or Tingling	o Yes o No
Leg or Foot Pain or Tingling	o Yes o No
Headaches	o Yes o No
Disc Herniation or Degeneration	o Yes o No
Dizziness or Balance Problems	o Yes o No
Fainting Spells	o Yes o No
Memory or Concentration Problems	o Yes o No
Bowel or Bladder Function Problems	o Yes o No
CANCER If so, what kind?	o Yes o No
Diagnosed Fibromyalgia	o Yes o No
Recent Fever or Chills	o Yes o No
Recent Unexplained Weight Loss	o Yes o No
Burning or Pain When You Urinate	o Yes o No
Chest Pain or Palpitations	o Yes o No
High Blood Pressure	o Yes o No
Chronic Cough	o Yes o No
Cardiac Pacemaker	o Yes o No
Scoliosis	o Yes o No
Diagnosed Osteoarthritis	o Yes o No
Diagnosed Rheumatoid Arthritis	o Yes o No
Shingles	o Yes o No
DIABETES If so, what type?	o Yes o No
Vomiting Within the Past Two Weeks	o Yes o No
Osteoporosis or Osteopenia	o Yes o No
Metal Implant / Appliance of Any Kind	o Yes o No
Visual Problems	o Yes o No
Hearing Problems	o Yes o No
Skin Problems If so, what type?	o Yes o No

List Medications Taking: Both Prescription & OTC

DO YOU SMOKE? How much a day?	o Yes o No
DO YOU DRINK? How often?	o Yes o No
(WOMEN) Any chance that you are pregnant?	o Yes o No
(WOMEN) Start of your last menstrual period?	DATE:_____

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HEALTH HISTORY (page two)

Have you ever had any of the following?	
Surgery on your neck	o Yes o No
Surgery on your back	o Yes o No
Hip Replacement Surgery	o Yes o No
Knee Replacement Surgery	o Yes o No
Cancer of Any Kind	o Yes o No
Stroke or TIA	o Yes o No
Heart Trouble	o Yes o No
Hepatitis	o Yes o No
Blood in Your Stool	o Yes o No
Thyroid Problems	o Yes o No
Tuberculosis	o Yes o No
Kidney Problems	o Yes o No
BROKEN BONES If so, please list:	o Yes o No

Have you EVER had ANY surgeries? o Yes o No
If Yes, List Below:

Have any of your close relatives had any of the following conditions? (mark the appropriate space)				
	MOTHER	FATHER	SIBLING	CHILD
NONE OF BELOW				
TUBERCULOSIS				
MIGRAINES				
CANCER				
SCOLIOSIS				
STROKE				
OSTEOARTHRITIS				
RHEUMATOID ARTHRITIS				

By signing below, you agree to be responsible for payment for services provided at Rush Chiropractic, Inc. at the time such services are provided, unless prior arrangements have been made. You also acknowledge and accept that no guarantees are made or implied that your condition will improve, and could even possibly worsen despite the best efforts of the Physicians and Staff of Rush Chiropractic, Inc. If you have any questions, please speak with our Staff before beginning treatment.

NAME (PRINT)_____

SIGNATURE_____ **DATE**____

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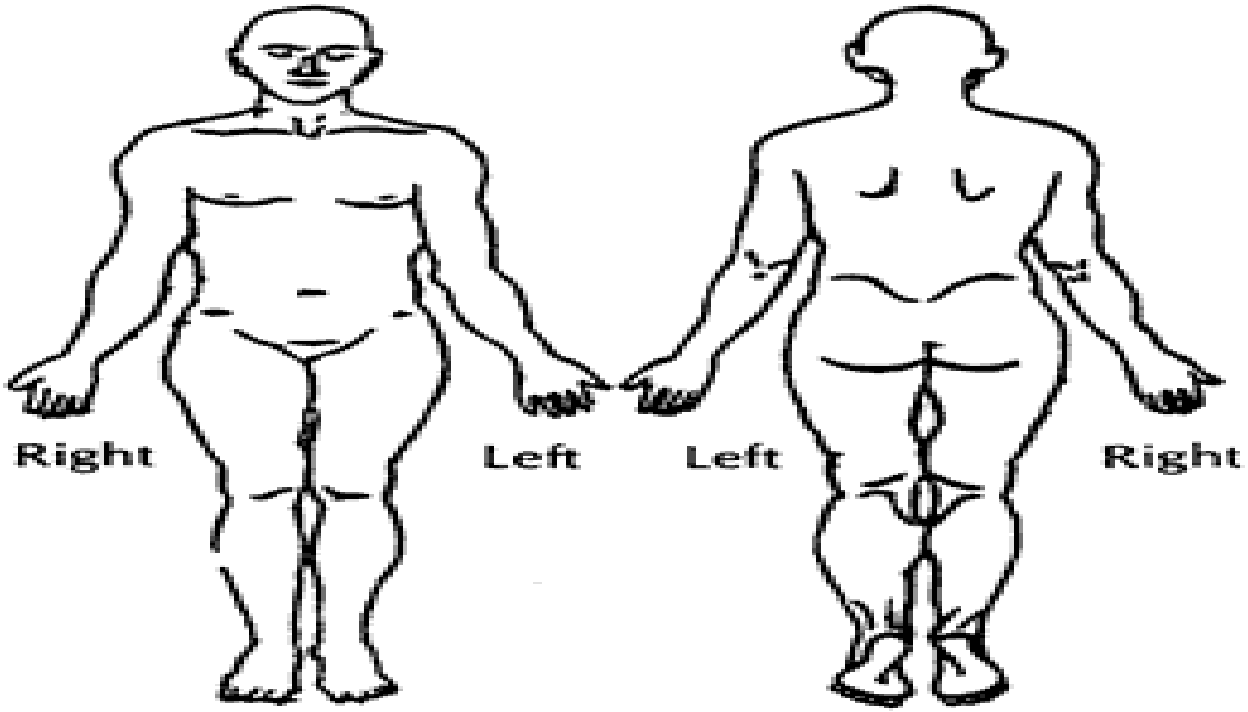
Name_____ Date_____

Please mark on the diagram where you currently have concerns.



1. What is your WORST Issue: _____

On a scale of **0 to 10** (10 being the worst), what would you **rate the severity**? _____

Frequency: ( ) Infrequent ( ) Occasional ( ) Frequent ( ) Constant

Describe the issue? ( )Sharp ( )Stabbing ( )Aching ( )Dull ( )Throbbing
( )Fiery ( )Numb/Tingling Other: _____

How long has the issue been there? _____

The issue is: ( )Getting worse ( )Staying the same ( )Getting better

What **activity** were you doing when it **started**? _____ ( ) Unknown

What makes it **better**? _____

What makes it **worse**? _____

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Name_____ Date_____

2. SECOND Issue: _____

On a scale of **0 to 10** (10 being the worst), what would you **rate the severity**? _____

Frequency: ( ) Infrequent ( ) Occasional ( ) Frequent ( ) Constant

Describe the issue? ( )Sharp ( )Stabbing ( )Aching ( )Dull ( )Throbbing
( )Fiery ( )Numb/Tingling Other:_____

How long has the issue been there? _____

The issue is: ( )Getting worse ( )Staying the same ( )Getting better

What **activity** were you doing when it **started**? _____ ( ) Unknown

What makes it **better**? _____

What makes it **worse**? _____

3. THIRD Issue: _____

On a scale of **0 to 10** (10 being the worst), what would you **rate the severity**? _____

Frequency: ( ) Infrequent ( ) Occasional ( ) Frequent ( ) Constant

Describe the issue? ( )Sharp ( )Stabbing ( )Aching ( )Dull ( )Throbbing
( )Fiery ( )Numb/Tingling Other: _____

How long has the issue been there? _____

The issue is: ( )Getting worse ( )Staying the same ( )Getting better

What **activity** were you doing when it **started**? _____ ( ) Unknown

What makes it **better**? _____

What makes it **worse**? _____