Albany County Chiropractic Center

Saratoga office
112 1/2 w. Bridge St.
307.326.4000
Kendra S. Sims D.C.

Laramie office
807 S.3 rd. St.
307.742.6840
Darren Bressler D.C. P.C

New Patient Packet

Please complete form below. Also bring any lab work that has been completed over the past year, list of immunizations, a list of current medications, vitamins, minerals, and/or herbal supplements, copies of MRI, X-rays, CT imaging, and/or reports.

PERSONAL INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Social Security #: _____ Sex: ◯ Male ◯ Female Location: ◯ Laramie ◯ Saratoga

Work Phone Number: _____ Cell Phone Number: _____ Home Phone Number: _____

Address: _____ Apt/Unit Number: _____

City: _____ State: _____ Zip Code: _____

EMPLOYMENT

Present Occupation or Source of Income: _____

Employer Name: _____

Employer Address: _____

Employer Phone: _____

EMERGENCY CONTACT

Emergency Contact ◯ Spouse ◯ Parent/Guardian ◯ Other _____

Full Name: _____

Phone Number: _____

Cell/Work Phone Number: _____

PRIMARY CARE PHYSICIAN

Name: _____

Date of Last Visit: _____ Reason for visit: _____

OVERALL HISTORY / HEALTH

Height: Waist Size: Weight:

Date of last:

Female Only

Eye Exam: Last Menstruation:

- ◯ Regular
- ◯ Irregular
- ◯ Other

Dental Exam: Last Pap:

Dermatologist: Breast Exam:

Colonoscopy: Mammogram:

Audiologist: (hearing) DEXA:

Physical:

List all surgeries:

List all hospitalizations:

List all fractures:

List all accidents/ injuries:

Primary reason for seeking care at our office:

Have you seen another healthcare professional for this problem:

- ◯ No
- ◯ Yes

Have you EVER had an MRI, X-ray, or other diagnostic imaging:

- ◯ No
- ◯ Yes

Do you use tobacco:

- ◯ No
- ◯ Yes

Do you drink alcohol:

- ◯ No
- ◯ Yes

Check all that applies if yes:

- ☐ Beer
- ☐ Wine
- ☐ Liquor

Drinks per day: Drinks per week:

What are your hobbies:

Averaged over the week, how much time do you spend on moderate to vigorous exercise and or physical activity:

What do you do:

Have you ever travelled outside the country:

- ◯ No
- ◯ Yes

How did you hear about or locate us:

FAMILY HISTORY

Please check the box if an immediate family member (parent, grandparent, or sibling) have previously or are currently receiving treatment for the following:

- ☐ Anemia
- ☐ Allergies
- ☐ Addiction
- ☐ Arthritis
- ☐ Cancer
- ☐ Lung Disease
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Reproductive Problems
- ☐ Diabetes
- ☐ Ulcer
- ☐ Kidney/Urinary Disease
- ☐ Thyroid Disease
- ☐ Depression/Mental Illness
- ☐ Stroke/Seizure
- ☐ Digestive Disease
- ☐ Muscle/Bone/Nerve Disease
- ☐ Other

List cause of death and age of deceased immediate family members:

SIGNS / SYMPTOMS

Please check all that applies currently or previously CONDITIONS:

- ☐ Abdominal pain or distention
- ☐ Acid Reflux/GERD
- ☐ Acne
- ☐ Bad Breath (halitosis)
- ☐ Bloating
- ☐ Bloody cough
- ☐ Bloody stool
- ☐ Bloody urine
- ☐ Blurry vision
- ☐ Breast lump or pain
- ☐ Chest pain
- ☐ Cold hands or feet
- ☐ Concussion
- ☐ Confusion
- ☐ Constipation
- ☐ Cough/Persistent or Chronic
- ☐ Dark stools
- ☐ Decreased libido
- ☐ Depression
- ☐ Diarrhea
- ☐ Difficult eating/swallowing
- ☐ Dizziness/vertigo
- ☐ Dry Throat or mouth
- ☐ Earaches
- ☐ Easily bruising
- ☐ Eye pain or strain
- ☐ Excessive phlegm
- ☐ Excessive saliva
- ☐ Fainting
- ☐ Fatigue- unchanged by rest
- ☐ Feeling full quickly
- ☐ Fever
- ☐ Frequent urination
- ☐ Gas/belching
- ☐ Goiter
- ☐ Grinding teeth
- ☐ Hair changes
- ☐ Hemorrhoids
- ☐ Hoarseness
- ☐ Impotence
- ☐ Irregular heartbeat
- ☐ Wheezing
- ☐ Increased thirst or urination
- ☐ Indigestion
- ☐ Intestinal cramps
- ☐ Irritability
- ☐ Itchy eyes
- ☐ Itchy skin
- ☐ Joint or bone pain
- ☐ Kidney stone
- ☐ Loss of hair
- ☐ Mouth sores
- ☐ Mucous in stools
- ☐ Nail changes
- ☐ Nasal congestion
- ☐ Night sweats
- ☐ Nose bleeds
- ☐ Numbness
- ☐ Pelvic pain
- ☐ poor appetite
- ☐ poor circulation
- ☐ poor memory
- ☐ poor sleep
- ☐ premature graying
- ☐ Psoriasis/eczema
- ☐ Rash
- ☐ Shortness of breath
- ☐ Sinus pressure
- ☐ Skin fungal infection
- ☐ Sleep difficulty
- ☐ Spots in eyes
- ☐ Sore throat
- ☐ Sudden energy drop
- ☐ Swollen glands
- ☐ Teeth/gum problems
- ☐ Tinnitus
- ☐ Tremor
- ☐ Ulceration
- ☐ Unsteady gait
- ☐ Urgent urination
- ☐ Vomiting
- ☐ Wake to urinate
- ☐ Weight loss/ gain
- ☐ None
- ☐ Other

Doctor use only:

MEDICATION LIST

List all prescription medicine/reason taking:	Prescribing Doctor:	Dates Prescribed:	Notes (Doctor use)

List all over the counter medicine/reason taking (e.g. tyenol, benadryl):			

List all herbal supplements/reason taking (e.g. ginseng, gingko, cinnamon):			

List all vitamins and minerals/reason taking (e.g. calcium, centrum silver, vitaman c):			

Supplement or medication allergies:

HEALTH HISTORY

Please check the box if you had or have any of the following conditions:

- ☐ Anemia
- ☐ Asthma
- ☐ Auto-immune Disease
- ☐ Bronchitis
- ☐ Childhood Illness
- ☐ Diabetes
- ☐ Gout
- ☐ Headache/migraine
- ☐ Hernia
- ☐ High cholesterol/trigylcerides
- ☐ Kidney Disease
- ☐ Mental Illness
- ☐ Nerve Disease
- ☐ Osteoporosis
- ☐ Prostate abnormalities
- ☐ Seizures
- ☐ STD
- ☐ Thyroid Disease or Irregularity
- ☐ Urinary Tract Infections (UTI)
- ☐ Allergy
- ☐ Arthritis
- ☐ Bone Disease
- ☐ Cancer
- ☐ COPD/Emphysema/other lung disease
- ☐ Food allergies
- ☐ Hay fever/ Seasonal allergies
- ☐ Heart Disease
- ☐ High blood pressure
- ☐ Incontinence
- ☐ Menstrual problems
- ☐ Muscle Disease
- ☐ Osteopenia
- ☐ PCOS(polycystic ovarian syndrome)
- ☐ Reproductive problems
- ☐ Skin Disease or Cancer
- ☐ Stroke/TIA
- ☐ Tuberculosis
- ☐ None
- ☐ Other not listed please explain

Doctor Notes:

Patient/ Guardian Signature:

Patient/Guardian Signature:

Today's Date

Today's Date

Doctor Signature:

Today's Date