Dr. Glenn J. Waldt

MS, DC, DO

Chiropractor & Medical Physician

2900 Hillrise Drive, Las Cruces, NM 88011, 505-695-1227

NEW PATIENT APPLICATION

Welcome to our Practice! Please thoroughly complete all questions. Thank you.

Patient Name_____ Today's Date_____

Birthdate_____ Age_____ Sex M / F E-Mail_____

Address_____City_____State____Zip_____

Phone_____Cell_____Work_____

Cell Carrier_____ Ok to receive text messages: yes no

Occupation_____Your Employer_____

Employer's Address_____

Marital Status M/W/D/S/P Their Name_____Their Employer_____

Children's Names & Ages _____

Prior Chiropractor_____Last appointment_____

Address_____ Phone_____

General Practitioner_____

Address_____ Phone_____

May we send a report of your findings to this Practitioner?____Yes ___No

Favorite Hobbies or Interests _____

Whom may we thank for referring you?_____

How Can We Help You?

What is the main reason for attending this practice? _____

If you are already experiencing symptoms, what is it? Please list your health concerns below, list WORST first)

Health Concerns (List worst first)	Severity 1=mild 10=unbearable	When did this episode start?	Did you have this condition before?	Started with an injury?	Constant? Intermittent?

Refering to your WORST problem:

→ Describe what kind of pain are you having numbness tingling stiffness dull aching cramping shooting burning stabbing sharp shooting throbbing swelling other :_____

→ Since your problem started, is it: About the same Getting Better Getting Worse

→ What makes it worse? _____

→ What makes it better? _____

→List any previous diagnosis and care you had for this problem: _____

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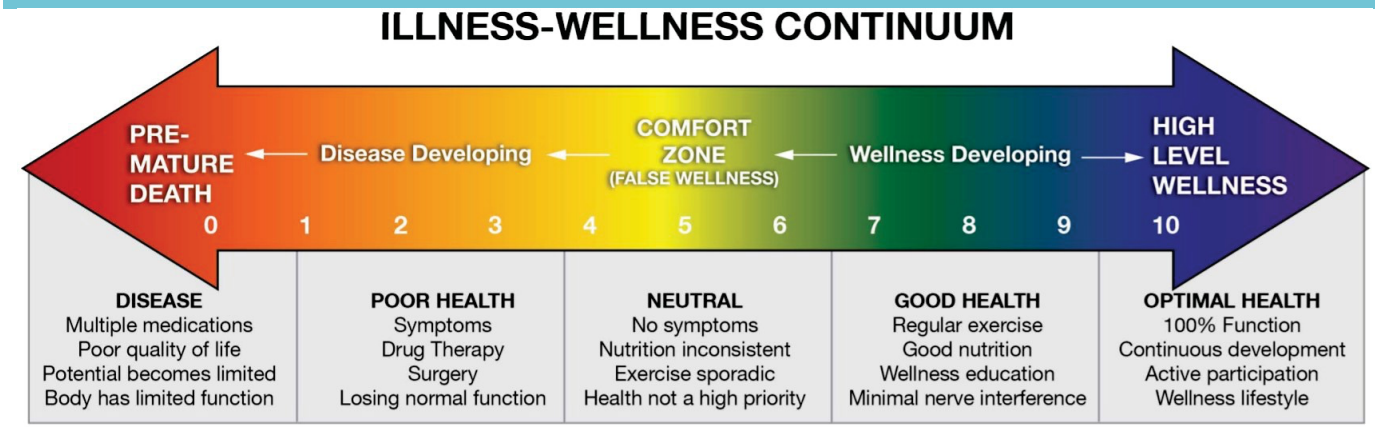
Impact of Your Symptoms

How is this symptom /condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work					Lifting				
Exercise					Sitting				
Relationships					Standing				
Sleep					Walking				
Self-care (washing, dressing)					Travel (driving)				
Energy					Other				

How committed are you to correcting this issue? (0 = not committed, 10 = very committed) _____

Patient Wellness Assessment



On the arrow diagram above:

→ What number do you think represents your health today? _____

→ In which direction is your health currently headed? _____

What are your health goals?

IMMEDIATE: _____

SHORT TERM: _____

LONG TERM: _____

Have you had any X-rays, MRI, CT Scan for your area(s) of complaint?____Yes ___No

Date Taken_____ What areas were taken?_____

Is this the result of an auto injury?____Yes ___No work injury?____Yes ___No

If so, when? _____

Other Doctors who have treated this problem_____

Father/Mother/Brother/Sister/Children, with similar problems?_____

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Please check all of the following that apply to you.

___Alcohol/Drug Dependence
___Recent Fever
___Diabetes
___High Blood Pressure
___Stroke (Date)_____
___Corticosteroid Use (Cortisone, Prednisone, etc.)
___Taking Birth Control Pills
___Dizziness/Fainting
___Numbness in Groin/Buttocks
___Osteoporosis

___Prostate Problems
___Menstrual Problems
___Urinary Problems
___Currently Pregnant, # Weeks ___
___Abnormal Weight___Gain_____Loss
___Marked Morning Pain/Stiffness
___Pain Unrelieved by Position or Rest
___Pain at Night
___Visual Disturbances
___Epilepsy/Seizures

___Tobacco Use – Type_____Frequency_____/Day

___Cancer/Tumor (Explain)_____

___Surgeries_____

___Medications_____

___Other Health Problems (Explain)_____

___None of the Above

What have you heard about chiropractic/osteopathic care?_____

Do you know what a subluxation is?____Yes ____No

What daily rituals for spinal health do you presently practice? _____

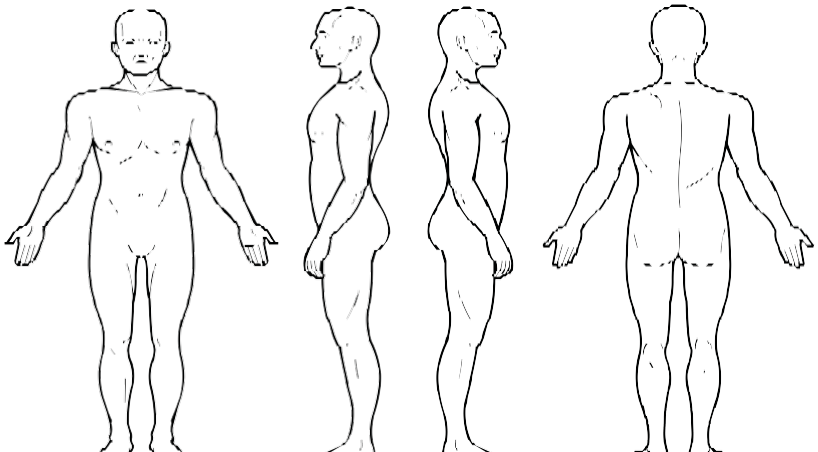
Client Consent

To the best of my knowledge, the above is a true and accurate history
I consent to undergo a professional and complete examination and treatment as needed.
I understand my financial obligation regarding this examination and payment is expected at time of service. Do you have health insurance? ___ Yes ___No Insurance Plan _____
Method of Payment for First Visit: ___ Cash ___ Check ___ Credit Card

Print Patient Name: _____ Signature: _____ Date: _____

PAIN ASSESSMENT DIAGRAM

MARK AREA(S) OF PAIN WITH AN X



SEVERITY OF YOUR PAIN

On a scale of 1-10 (0 is no pain and 10 is worst), answer the following.

What level is your pain currently? ____

What is your level of pain at best? ____

At its worst? ____

Where is your worst pain? _____

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PREVIOUS TREATMENTS

HAVE YOU BEEN EVALUATED BY:

☐ Osteopathic Physician
☐ Orthopedic Surgeon
☐ Spine Surgeon
☐ Neurosurgeon
☐ Physical Medicine (PMR)
☐ Neurologist
☐ Psychiatrist/Psychologist
☐ Physical Therapist (PT)

SURGICAL PROCEDURES/ INTERVENTIONS

☐ Cervical fusion
☐ Vertebroplasty
☐ Kyphoplasty
☐ Lumbar laminectomy w/wo fusion
☐ Shoulder/rotator cuff repair/tenodesis
☐ Carpal tunnel release
☐ Total hip/knee arthroplasty (THA/TKA)
☐ Radiofrequency ablation (RFA)
☐ Other_____

OTHER SURGICAL HISTORY

☐ Tonsillectomy
☐ Thyroidectomy
☐ Gallbladder removal
☐ Appendectomy
☐ Hernia repair
☐ Bypass (CABG)
☐ Angioplasty w/wo stent
☐ Pacemaker/defibrillator
☐ Other_____

HAVE YOU EVER HAD OR BEEN DIAGNOSED WITH THE FOLLOWING?

☐ Cervical (neck) trauma
☐ Known coagulation defect
☐ Inflammatory spondylopathy
☐ Osteoporosis
☐ Aortic aneurysm/dissection
☐ Chronic anticoagulant therapy

PREVIOUS INJECTION THERAPY

☐ Platelet Rich Plasma (PRP)
☐ Perineural Injection Treatment (PIT)
☐ Prolotherapy
☐ Epidural steroid INJ
☐ Facet INJ (cervical/thoracic/lumbar)
☐ Sacroiliac joint INJ
☐ Trigger point INJ
☐ Shoulder/hip/knee INJ
☐ Steroid INJ
☐ Synvisc/Monovisc INJ
☐ Tenotomy/dry needling
☐ Other_____

Anything Else:_____

MEDICATION THERAPY

PAIN RELIEVER/NSAIDs:

☐ Tylenol (Acetaminophen)
☐ Motrin (Ibuprofen)
☐ Aleve (Naproxen)
☐ Mobic (Meloxicam)
☐ Celebrex (Celecoxib)
☐ Voltaren Gel (Diclofenac)
☐ Other

MUSCLE RELAXER:

☐ Flexeril (Cyclobenzaprine)
☐ Robaxin (Methocarbamol)
☐ Norflex (Orphenadrine)
☐ Zanaflex (Tizanidine)
☐ Gablofen (Baclofen)
☐ Soma (Carisoprodol)

NERVE MEDICINE:

☐ Neurontin (Gabapentin)
☐ Lyrica (Pregabalin)

BENZODIAZEPINES:

☐ Valium (Diazepam)
☐ Ativan (Lorazepam)
☐ Versed (Midazolam)
☐ Klonopin (Clonazepam)

NARCOTICS/OPIATES/OPIOIDS:

☐ Duragesic (Fentanyl)
☐ Dilaudid (Hydromorphone)
☐ Ultram (Tramadol)
☐ Methadone
☐ Norco/Lortab/Vicodin (Hydrocodone)
☐ Oxycontin/Percocet (Oxycodone)

DOSING (please circle):

☐ 5mg/325mg
☐ 7.5mg/325mg
☐ 10mg/325mg
☐ Other

ANTI-DEPRESSANTS (SSRI/SNRI/TCA):

☐ Prozac (Fluoxetine)
☐ Effexor (Venlafaxine)
☐ Celexa (Citalopram)
☐ Lexapro (Escitalopram)
☐ Elavil (Amitriptyline)

SLEEP MEDICINE:

☐ Ambien (Zolpidem)
☐ Lunesta (Eszopiclone)
☐ Restoril (Temazepam)
☐ Halcion (Triazolam)

ANXIETY, PSYCH, OR OTHER MEDICATIONS: _____

_____

PATIENT SIGNATURE **DATE** **PHYSICAN REVIEWED** **DATE**