Welcome!

Please fill this short form. We protect your privacy and maintain confidentiality in accordance to U.S. HIPAA regulations.

A New Way Clinic
MODERN • NATURAL • MEDICINE

Name _____ DOB _____

Phone (Mobile) _____Email Address_____

Address _____ City _____ State/Prov. _____ Zip _____

How did you hear about us? _____

Occupation _____ Do you have? ☐ Medicare ☐ Medicaid ☐ Other

Please check off any of the following where you experience pain or any conditions you suffer from:

☐ Knee pain	☐ Cardiovascular Problems	☐ Autoimmune Disease
☐ Knee degenerative disease	☐ Low back pain	☐ Fibromyalgia
☐ Degenerative Disc Disease	☐ Hypertension	☐ Sleep problems
☐ Neck Pain	☐ Diabetes	☐ Neuropathy
☐ Arthritis	☐ Decline memory	☐ Rheumatoid Arthritis

Any Other Health Conditions not listed above?

_____

Which of the above is the worst?

_____

How long have you had this condition?

_____

How often does it occur? (daily, weekly, monthly?)

_____

What is your pain on a scale of 1-10? Choose an item.

Has anything helped this problem? _____

Does this cause you to suffer from?

☐Irritability
☐Interrupted Sleep
☐Restricted daily Activity
☐Mood disorder
☐Fatigue
☐Unable to Work Long Hours

Does this affect your life?

☐Lose patience with Spouse, Friends or Family
☐Restricted Household Duties
☐Holds you back from Exercise or Practice Sports
☐Interferes with Ability to Participate in Hob

I understand that the purpose of the consultation is to permit issues which are causing distress to be understood thoroughly enough to recommend a course of action. I understand that the consultation is not a medical evaluation or treatment. At the conclusion, the provider will discuss the findings and will recommend to me with the best course of action to address the problem.

Patient name (print) _____ Date _____

Signature _____