New Patient Health History Form

In order to provide you the best possible wellness care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

Name ________________________________ Date ________ Email ____________________________________

Your email will NOT be shared with any 3d parties, and is used for occasional office announcements and promotions.

Mailing address

Address ____________________________________ City ______________ State _______________ Zip _______

Telephone (Cell) _______________ (Home) ________________ (Work)_____________ Referred By __________

Age ______ Birth date _________ Social Security # _____________ Number of children __________

Occupation ____________________________ Employer____________________ Marital Status____________

Spouse's name _________________ Spouse's D.O.B.________________ Spouse's SS#_________________

Spouse's Occupation _________________ Spouse's Employer ___________________

Emergency Contact ________________________ Phone ____________________

Current Complaints

Nature of injury: Automobile* ❑ Work ❑ Other ❑

Please describe ____

____

Date of injury _____________ Date symptoms appeared _____________

Have you ever had same condition? ❑ No ❑ Yes If yes, when? ___________________________

List other practioners seen for this injury/condition ____

Have you ever been under chiropractic care? ❑ No ❑ Yes

If yes, please describe ____

Insurance Information

Name of party responsible for payment ________________________ Phone _______________________

Do you have health insurance? ❑ No ❑ Yes Name of company __________________________

*** If an auto accident please provide:**

Insurance company name ________________________ Contact person ____________________________

Phone ______________________________ Claim # ____

Billing Address

Name of the insured ____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature ____ Date __________________

Spouse's or guardian's signature ________________________________ Date __________________

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Medical History

Have you been treated for any conditions in the last year? ❑ No ❑ Yes
If yes, please describe ______________________________
Date of last physical exam ________________.
Is there a chance that you are pregnant? ❑ No ❑ Yes If so, date of last period __________________
How Far Along?______________________
Have you had X-rays taken? ❑ No ❑ Yes If yes, where? ________________________________
What medications are you taking and for what conditions (Please list dosage and amounts, etc).
____
____
What vitamins, minerals, or herbs do you currently take? (Please list for what condition, dosage, and frequency).
____
____

Have you ever:	No	Yes	Briefly Explain
Broken bones?	❑	❑	______________
Been hospitalized?	❑	❑	______________
Been in an auto accident?	❑	❑	______________
Had Sprains/Strains?	❑	❑	______________
Been struck unconscious?	❑	❑	______________
Had surgery?	❑	❑	______________

Family History

Family Member	Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	❑ No ❑ Yes
Do your symptoms interfere with daily life?	❑ No ❑ Yes
Does pain wake you up at night?	❑ No ❑ Yes
Are your symptoms worse during certain times of the day?	❑ No ❑ Yes
Do changes in weather affect your symptoms?	❑ No ❑ Yes
Do you wear orthotics?	❑ No ❑ Yes
Do you take vitamin supplements?	❑ No ❑ Yes
What activities aggravate your symptoms?	❑ No ❑ Yes

____
____
____

Habits	None	Light	Moderate	Heavy
Alcohol	❑	❑	❑	❑
Coffee	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑
Drugs	❑	❑	❑	❑
Exercise	❑	❑	❑	❑
Sleep	❑	❑	❑	❑
Appetite	❑	❑	❑	❑
Soft Drinks	❑	❑	❑	❑
Water	❑	❑	❑	❑
Salty Foods	❑	❑	❑	❑
Sugary Foods	❑	❑	❑	❑
Artificial Sweeteners	❑	❑	❑	❑

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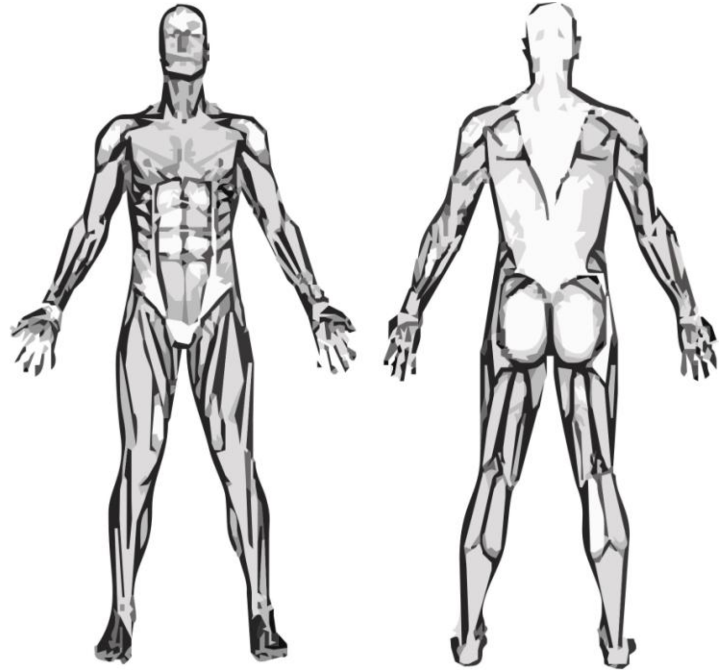
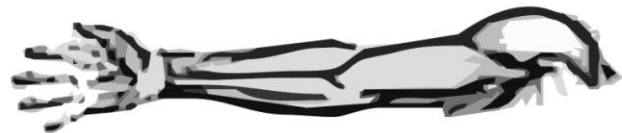
Have you ever suffered from:	Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.
❑ Alcoholism ❑ Allergies ❑ Anemia ❑ Arteriosclerosis ❑ Arthritis ❑ Asthma ❑ Back Pain ❑ Breast lump ❑ Bronchitis ❑ Bruise Easily ❑ Cancer ❑ Chest Pain/Conditions ❑ Cold extremities ❑ Constipation ❑ Cramps ❑ Depression ❑ Diabetes ❑ Digestion Problems ❑ Dizziness ❑ Ears Ring ❑ Excessive Menstruation ❑ Eye Pain/Difficulties ❑ Fatigue ❑ Frequent Urination ❑ Headache ❑ Hemorrhoids ❑ High Blood Pressure ❑ Hot Flashes ❑ Irregular Heart Beat ❑ Irregular Cycle ❑ Kidney Infection ❑ Kidney Stones ❑ Loss of memory Loss of balance ❑ Loss of smell ❑ Loss of taste ❑ Lumps In Breast ❑ Neck Pain or Stiffness ❑ Nervousness ❑ Nosebleeds ❑ Pacemaker ❑ Polio ❑ Poor Posture ❑ Prostate Trouble ❑ Sciatica ❑ Shortness of breath ❑ Sinus Infection ❑ Sleep problems/insomnia ❑ Spinal Curvatures ❑ Stroke ❑ Swelling of ankles ❑ Swollen Joints ❑ Thyroid Condition ❑ Tuberculosis ❑ Ulcers ❑ Varicose Veins ❑ Venereal Disease ❑ Other:	**A**=Ache **O**=Other **B**=Burning **P**=Pins & Needles **N**=Numbness **S**=Stabbing  

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