

New Patient Health History Form

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

Patient Data

First Name Last 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 (Work) (Home) (Cell)

Age Birth Date Social Security # Number of Children

Occupation Employer

Marital Status Spouse's Name Spouse's Occupation

Spouse's Employer Spouse's Health Status

Emergency Contact Phone

How did you hear of our office

Current Complaints

Nature of Injury: Automobile* Work Other

Please describe:

• Date if Injury Date symptoms appeared

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

List of other practitioners 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? Yes No Name of company

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

Insurance Company Name Contact Person

Phone: Claim #

Do you have an attorney? Yes No If yes, who

Signatures

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 _____

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

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 conditions, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been hospitalized?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been in an auto accident?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Had Sprains/Strains?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been struck unconscious?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Had surgery?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>

Family History

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

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

Habits	None	Light	Moderate	Heavy
Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coffee	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tobacco	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Appetite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Soft Drinks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Water	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Salty Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sugary Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Artificial Sweeteners	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Have you ever suffered from:

- | | |
|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> muscle spasms |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> numbness/tingling |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> joint pain |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> weakness |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> ear infections |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> vision problems |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> poor memory |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> heart attack |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> blood clots |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> indigestion |
| <input type="checkbox"/> Chest Pain/Conditions | <input type="checkbox"/> colon/bowel trouble |
| <input type="checkbox"/> Cold Extremities | <input type="checkbox"/> vomiting |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> Cramps | <input type="checkbox"/> weight loss/gain |
| <input type="checkbox"/> Depression | <input type="checkbox"/> fever/chills |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> anxiety |
| <input type="checkbox"/> Digestion Problems | <input type="checkbox"/> epilepsy/convulsions |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> menstrual problems |
| <input type="checkbox"/> Ears Ring | <input type="checkbox"/> anxiety |
| <input type="checkbox"/> Excessive Menstruation | <input type="checkbox"/> rash/skin lesion |
| <input type="checkbox"/> Eye Pain or Difficulties | <input type="checkbox"/> hair/nail changes |
| <input type="checkbox"/> Fatigue | |
| <input type="checkbox"/> Frequent Urination | |
| <input type="checkbox"/> Headache | |
| <input type="checkbox"/> Hemorrhoids | |
| <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> Hot Flashes | |
| <input type="checkbox"/> Irregular Heart Beat | |
| <input type="checkbox"/> Irregular Cycle | |
| <input type="checkbox"/> Kidney Infection | |
| <input type="checkbox"/> Kidney Stones | |
| <input type="checkbox"/> Loss of memory | |
| <input type="checkbox"/> Loss of balance | |
| <input type="checkbox"/> Loss of smell | |
| <input type="checkbox"/> Loss of taste | |
| <input type="checkbox"/> Lumps In Breast | |
| <input type="checkbox"/> Neck Pain or Stiffness | |
| <input type="checkbox"/> Nervousness | |
| <input type="checkbox"/> Nosebleeds | |
| <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> Polio | |
| <input type="checkbox"/> Poor Posture | |
| <input type="checkbox"/> Prostate Trouble | |
| <input type="checkbox"/> Sciatica | |
| <input type="checkbox"/> Shortness of breath | |
| <input type="checkbox"/> Sinus Infection | |
| <input type="checkbox"/> Sleep problems or Insomnia | |
| <input type="checkbox"/> Spinal Curvatures | |
| <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Swelling of ankles | |
| <input type="checkbox"/> Swollen Joints | |
| <input type="checkbox"/> Thyroid Condition | |
| <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Ulcers | |
| <input type="checkbox"/> Varicose Veins | |
| <input type="checkbox"/> Venereal Disease | |
| <input type="checkbox"/> Other: <input type="text"/> | |

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache =Other
*****=Burning **P**=Pins & Needles
N=Numbness (=Stabbing)

