

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

First Name Last Name Date Email*
*your email will NOT be shared with any 3rd parties, and is used for occasional office announcements and promotions

Mailing address

Address City State Zip
Phone (work) (cell) (home) referred by
Age Birth Date Social Security# Number of Children
Occupation Employer
Marital Status Spouse's Name/Occupation
Spouse's Employer Spouse's Health Status
Emergency Contact Phone

Current Complaint

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?
Have you ever been under chiropractic care? No yes
List of other practitioners seen for this injury/condition

Insurance Information

Do you have Health Insurance No Yes (complete below)
Name of Insurance company Phone
If an auto accident, please include: Contact Person
Claim # Phone

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 Signature _____ Date _____
Spouse's/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 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"/> | |
| Been hospitalized? | <input type="radio"/> | <input type="radio"/> | |
| Been in an auto accident? | <input type="radio"/> | <input type="radio"/> | |
| Had Sprains/Strains? | <input type="radio"/> | <input type="radio"/> | |
| Been struck unconscious? | <input type="radio"/> | <input type="radio"/> | |
| Had surgery? | <input type="radio"/> | <input type="radio"/> | |

Family History

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

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

| 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:

- Alcoholism
- Allergies
- Anemia
- Arteriosclerosis
- Arthritis
- Asthma
- Back Pain
- Bronchitis
- Bruise Easily
- Cancer
- Chest Pain/Conditions
- Cold Extremities
- Constipation
- Cramps
- Depression
- Diabetes
- Digestion Problems
- Dizziness
- Ears Ring
- Excessive Menstruation
- Eye Pain or 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 or Insomnia
- Spinal Curvatures
- Stroke
- Swelling of ankles
- Swollen Joints
- Thyroid Condition
- Tuberculosis
- Ulcers
- Varicose Veins
- Venereal Disease
- Other:

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

A=Ache O=Other
B=Burning P=Pins & Needles
N=Numbness S=Stabbing



