



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 _____ E-mail _____
Your e-mail will NOT be shared with 3rd parties, and is used for general office announcements and promotions

MAILING ADDRESS

Address _____ City _____ State _____ Zip _____
Telephone (work) _____ (home) _____ (cell) _____
Age _____ Birth date _____ Social Security # _____ Driver's License # _____
Occupation _____ Employer _____ Referred by _____
Marital status _____ Spouse's name _____ Spouse's occupation _____
Spouse's employer _____ Spouse's health status _____ Number of children _____
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 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? No Yes Name of company _____
**If auto accident, please provide:*
Insurance company name _____ Contact person _____
Phone _____ Claim # _____

PATIENT RESPONSIBILITY

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 guardians signature _____ Date _____

MEDICAL HISTORY

Have you ever 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 frequency.) _____

What vitamins, minerals, or herbs do you currently take? (Please list for what condition, dosage, and frequency.) _____

HAVE YOU EVER: NO YES BRIEFLY EXPLAIN

HAVE YOU EVER:	NO	YES	BRIEFLY EXPLAIN
Broken bones?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been in an auto accident?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had sprains/strains?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been struck unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____

FAMILY HISTORY

Family Member	Present/Past Health Conditions (i.e. heart disease, cancer, diabetes, arthritis)

TO BE COMPLETED BY/WITH THE DOCTOR:

HABITS: NONE LIGHT MODERATE HEAVY

Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Have you ever suffered from:

Alcoholism	<input type="checkbox"/>
Allergies	<input type="checkbox"/>
Anemia	<input type="checkbox"/>
Arteriosclerosis	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>
Asthma	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>
Bruise Easily	<input type="checkbox"/>
Cancer	<input type="checkbox"/>
Chest Pain/Conditions	<input type="checkbox"/>
Cold Extremities	<input type="checkbox"/>
Constipation	<input type="checkbox"/>
Cramps	<input type="checkbox"/>
Depression	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>
Digestion Problems	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>
Excessive Menstruation	<input type="checkbox"/>
Eye Pain/Difficulties	<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"/>
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/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="checkbox"/>

CURRENT COMPLAINTS (CONTINUED)

Please use the following letters to indicate **TYPE** and **LOCATION** of the symptoms you are experiencing:

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

