

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 3d parties, and is used for occasional office announcements and promotions.

Mailing address

Address City State Zip
Telephone (Work) (home) Referred By
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

Current Complaints

Nature of Injury:

Please describe:

Date if Injury Date symptoms appeared

Have you ever had same condition? If yes, when?

List of other practitioners seen for this injury/condition

Have you ever been under chiropractic care?

If yes, please describe

Insurance Information

Name of party responsible for payment Phone

Do you have health insurance? Name of company

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

Insurance Company Name Contact Person

Phone: Claim #

Signatures

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the Chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the Chiropractor or Chiropractic group insurance benefits otherwise payable to me. I understand that my Chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Name of the insured _____

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Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

Medical History

Have you been treated for any conditions in the last year?

If yes, please describe

Date of last physical exam

Is there a chance that you are pregnant?

Have you had X-rays taken?

If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts,

etc)l

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? Been hospitalized? Been in an auto accident? Had Sprains/Strains? Been struck unconscious? Had surgery?			

Family History

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

Do you experience pain every day? Do your symptoms interfere with daily life? Does pain wake you up at night? Are your symptoms worse during certain times of the day? Do changes in weather affect your symptoms? Do you wear orthotics? Do you take vitamin supplements? What activities aggravate your symptoms?	
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Habits	None	Light	Moderate	Heavy
Alcohol Coffee Tobacco Drugs Exercise Sleep Appetite Soft Drinks Water Salty Foods Sugary Foods Artificial Sweeteners				

Have you ever suffered from:	
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- 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 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

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
