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)_____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: ◯ 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? ◯ No ◯ Yes Name of company_____

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

Insurance Company Name_____ Contact Person_____

Phone:_____ Claim #_____

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)I

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?	◯	◯	_____

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

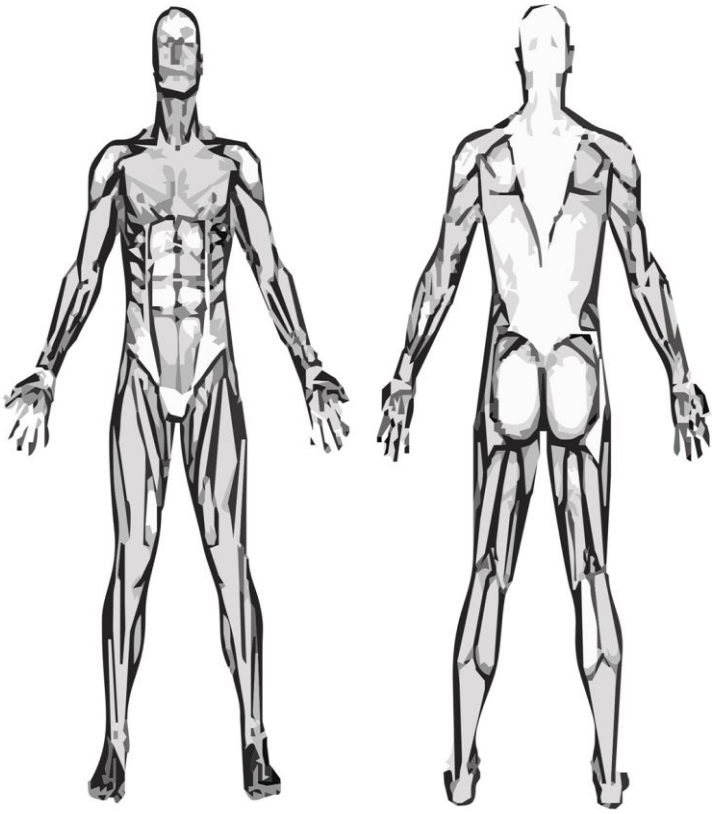
Habits	None	Light	Moderate	Heavy
Alcohol	◯	◯	◯	◯
Coffee	◯	◯	◯	◯
Tobacco	◯	◯	◯	◯
Drugs	◯	◯	◯	◯
Exercise	◯	◯	◯	◯
Sleep	◯	◯	◯	◯
Appetite	◯	◯	◯	◯
Soft Drinks	◯	◯	◯	◯
Water	◯	◯	◯	◯
Work Activity	◯	◯	◯	◯

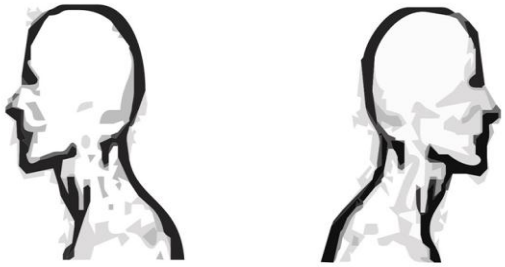
Have you ever suffered from:

- 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
- 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





Rate the Severity of your pain

1 2 3 4 5 6 7 8 9 10

Least pain Severe pain