

# 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)  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 of 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.)

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:**

- 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

