URBAN HEALTH GROUP

Baseline Concussion Testing: Health History

Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Name:_____Today's Date: _____
Address:_____ City: _____Postal Code: _____
Home Phone: _____ Cell: _____Email: _____
Gender: _____ Age: _____ Date of Birth: _____
Occupation: _____ Years of Education Completed _____
Who may we thank for referring you to our office? _____

Please list current sports and teams:

_____
_____
_____
_____

How many concussions do you think you have had in the past? _____
When was the most recent concussion? _____

Please circle:

Have you ever been hospitalized or had medical imaging done for a head injury?	Y	N
Have you ever been diagnosed with headaches or migraines?	Y	N
Do you have a learning disability (dyslexia, ADHD, etc?)	Y	N
Have you ever been diagnosed with depression, anxiety or any other psychiatric disorder?	Y	N
Has anyone in your family ever been diagnosed with any of the above disorders?	Y	N
Are you currently taking any medication or supplements? If yes, please list:	Y	N

_____

Please list any accidents and/or injuries (Automobile, bicycle, sports, playground, etc.) and the date of the injury:

_____ Date: _____
_____ Date: _____
_____ Date: _____

Please list any surgeries you have had and the date of the surgery:

_____ Date: _____
_____ Date: _____
_____ Date: _____

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Please check any symptoms you have ever had, past or present:

- ☐ Headaches
- ☐ Sinus trouble
- ☐ Jaw pain
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Frequent colds/flus
- ☐ Allergies/ Hay fever
- ☐ Asthma
- ☐ Chronic cough
- ☐ Thyroid trouble
- ☐ Fatigue
- ☐ Sleeping trouble
- ☐ Depression
- ☐ Ear ache
- ☐ Fainting/ dizziness
- ☐ Loss of balance
- ☐ Ringing in ears
- ☐ Blurred vision
- ☐ Neck pain
- ☐ Shoulder/ arm pain
- ☐ Pins and needles in arms
- ☐ Numbness in fingers
- ☐ Cold hands
- ☐ Midback pain
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ High/low blood pressure
- ☐ Anemia
- ☐ Tension/ Nervousness
- ☐ Irritability
- ☐ Indigestion
- ☐ Ulcers
- ☐ Intestinal gas/bloating
- ☐ Low back pain
- ☐ Arthritis
- ☐ Skin problems
- ☐ Numbness in legs/feet
- ☐ Leg or foot pain
- ☐ Constipation
- ☐ Urinary problems
- ☐ Menstrual pain/ irregularity
- ☐ Swelling in joints
- ☐ Cold feet
- ☐ Hip pain

Are you currently seeing any health professionals for any of these symptoms or conditions? If yes, please list:

_____
_____
_____
_____

Consent:
I consent to a professional and complete examination. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature _____Date: _____

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