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 ADDRESS

**Your email will not be shared with any 3rd parties, and is used for occasional office announcements and promotions.*

Whom may we thank for referring you to our office today?	Would you like to Opt In for Text Message Appointment Reminders? ◎ Yes ◎ No

MAILING ADDRESS

ADDRESS			CITY

STATE	ZIP CODE	HOME PHONE	CELL PHONE

AGE	BIRTH DATE	SOCIAL SECURITY #	OCCUPATION

MARITAL STATUS	SPOUSE'S NAME	SPOUSE'S OCCUPATION

NAMES & AGES OF MINOR CHILDREN

IN AN EMERGENCY CONTACT:	PHONE

CURRENT COMPLAINTS

NATURE OF INJURY/ONSET: ◎ Automobile* ◎ Work ◎ Other	DATE OF INJURY/ONSET

PLEASE DESCRIBE YOUR INJURY/COMPLAINT:

WHEN DID YOUR SYMPTOMS FIRST APPEAR?	HAVE YOU EVER HAD THE SAME CONDITION? ◎ Yes ◎ No	IF YES, WHEN?

PLEASE LIST OTHER PRACTITIONERS SEEN FOR THIS INJURY/CONDITION

HAVE YOU EVER BEEN UNDER CHIROPRACTIC CARE? ◎ Yes ◎ No	IF YES, PLEASE DESCRIBE:

INSURANCE INFORMATION

NAME OF PARTY RESPONSIBLE FOR PAYMENT	PHONE

DO YOU HAVE HEALTH INSURANCE? ◎ Yes ◎ No	NAME OF HEALTH INSURANCE COMPANY

***IF AN AUTO ACCIDENT, PLEASE PROVIDE:**

INSURANCE COMPANY NAME	POLICY NUMBER	CLAIM NUMBER

CONTACT PERSON	CONTACT PHONE NUMBER

SIGNATURES

NAME OF THE INSURED _____

I understand and agree that health/accident insurance policies are an arrangement between me and my insurance company. 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, any fees for professional services rendered to me will be immediately due and payable. Further, by my signature, I hereby give the doctor consent to treat my condition following a report of findings of my initial exam.

PATIENT'S SIGNATURE _____ DATE _____

SPOUSE'S OR GUARDIAN'S SIGNATURE _____ DATE _____

MEDICAL HISTORY

Have you been treated for any conditions in the last year? ◎ Yes ◎ No | IF YES, PLEASE DESCRIBE:

Is there any chance that you are pregnant? ◎ Yes ◎ No

What medications are you taking and for what conditions?

What vitamins, minerals or herbs do you currently take?

PLEASE ANSWER

			BRIEFLY DESCRIBE/EXPLAIN
Have you broken any bones?	◎ Yes	◎ No	
Have you been hospitalized?	◎ Yes	◎ No	
Have you been in an auto accident?	◎ Yes	◎ No	
Have you had any Sprains/Strains?	◎ Yes	◎ No	
Have you been struck unconscious?	◎ Yes	◎ No	
Have you had surgery?	◎ Yes	◎ No	
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? If so, when?	◎ Yes	◎ No	

What activities aggravate your symptoms?

HABITS	NONE	LIGHT	MODERATE	HEAVY		NONE	LIGHT	MODERATE	HEAVY
Alcohol	☐	☐	☐	☐	Appetite	☐	☐	☐	☐
Coffee	☐	☐	☐	☐	Soft Drinks	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐	Water	☐	☐	☐	☐
Recreational Drugs	☐	☐	☐	☐	Salty Foods	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Stress	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Sugary Foods	☐	☐	☐	☐

IN THE PAST YEAR, HAVE YOU SUFFERED FROM: *(Please check all that apply)*

- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Frequent Urination
- ☐ Headache
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of balance
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of breath
- ☐ Sinus Infection
- ☐ Sleep problems or Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Ulcers
- ☐ Varicose Veins

☐ Other: *(Please describe)* _____

Using Key below, indicate and label location of your discomfort in the body outlines and rate them from 1 to 10 *(1 being mild and 10 extreme).*

A – Ache **B** – Burning **D** – Dull Pain **N** – Numbness **P** – Spasm **S** – Stiff **T** – Tingling **X** – Sharp

O – Other *(Please describe)*