

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: 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"/>	_____
Been hospitalized?	<input type="radio"/>	<input type="radio"/>	_____
Been in an auto accident?	<input type="radio"/>	<input type="radio"/>	_____
Had Sprains/Strains?	<input type="radio"/>	<input type="radio"/>	_____
Been struck unconscious?	<input type="radio"/>	<input type="radio"/>	_____
Had surgery?	<input type="radio"/>	<input type="radio"/>	_____

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?

No Yes
 No Yes
 No Yes
 No Yes
 No Yes
 No Yes
 No 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"/>

Name: _____

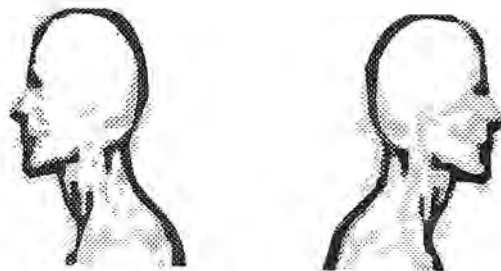
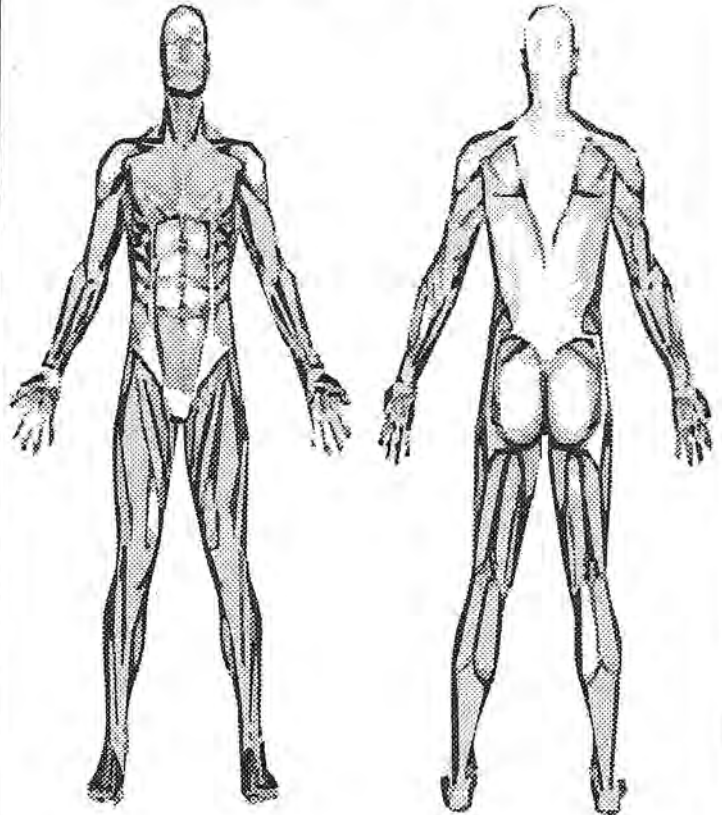
Date: _____

Do you currently suffer 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



Name: _____

Date: _____