Patient Health History

Today's Date_____________ Patient Title: (check one) ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.
First Name____Middle Name____________________
Last Name____DOB____/____/______ Age_________
Address____SSN_____________________
City____State________________Zip Code_______________
Primary Phone___________________________________Work Phone_______________________________
Mobile Phone_____________________________ Email____
(By providing my email I authorize my Doctor to contact me by email)
Preferred Contact Method (Circle one) Primary Phone Work Phone Mobile Phone

Employment Status (Circle One) Employed Self-Employed Retired FT Student Other
Occupation____ Employer________________________________
Work Address____

Spouse's Name________________________________DOB____/_____/____SSN___________________
Spouse's Employer____Work Phone__________________________
Emergency Contact:__________________________Relationship:________________Phone_______________

Referred By____
Have you received Chiropractic Care before? Y N if Yes when/where___________________________
List chief complaints 1)__________________________________date symptoms started_________________
2)__________________________________date symptoms started_________________
What functions are affected by pain? (Example: walking sitting, bending, laying, etc.) List All
____
Have you missed any work because of these symptoms? Y N If yes, when?_______________________
Was this related to an accident? Y N If Yes: Auto At Work Other_________________________
Accident date____/_____/_____ Describe accident____
____
List Doctors consulted for your current condition Primary Care Physician_________________________
1)____ Diagnosis_____________________________________
2)____ Diagnosis_____________________________________

Financial Arrangements

Method of Payment: Check Cash Debit/Credit Do you want us to file your Insurance Y N
Insurance Company______________________________ Secondary Insurance______________________________
Name of Policy Holder___________________________ Name of Policy Holder___________________________
DOB_____/_____/_____ Employer:_________________ DOB____/_____/____ Employer:___________________
Address if different from above____Primary Ins or Secondary
Clinic policy requires payment arrangements be made on the first visit and/or Insurance verification.

Patient Signature:____Date_____/_____/________
(If minor Parent/Guardian)

This box to be completed by Clinic Staff:
Height:__________inches Weight________ lbs. Blood Pressure_______/_______ Pulse_________

Personal History

Presently have

___Cancer
___High Blood Pressure
___Heart Trouble
___Chest Pain
___Shortness of Breath
___Diabetes
___Hypoglycemia
___Hepatitis
___Multiple Sclerosis
___Epilepsy
___Concussion
___Dizziness/Fainting
___Arthritis
___Neuritis
___Bursitis
___Rheumatic Fever
___Asthma
___Digestive Disorder
___Bowel Trouble
___Constipation
___Diarrhea
___Osteoporosis
___Numbness
___Headache
___Low Back Pain
___Stroke
___Anemia
___Kidney Problems
___Trouble Urinating
___Muscle Spasms
___Leg Cramps
___Swelling of Hands or Feet
___Grinding Sounds of neck
___Depression
___Chronic Fatigue
___Weight Loss
___Weight Gain
___Scoliosis
___Sinus Trouble
___Neck Pain
___Pacemaker

Women Only

___Birth Control Pills
___Hysterectomy
___Menstrual Pain
___Breast Pain
Pregnant? Yes No

Men Only

___ Prostate Trouble
___ Leakage after urination

Everyone

___ Drink coffee __Cups/Day
___Drink Tea__Cups/Day
___Drink Alcohol; Frequency: ___times per
(Please Circle One): Week/Month/Times

Number of Children & Ages____________
____

Family History

___Cancer
___High Blood Pressure
___Low Back Pain
___Heart Trouble
___Diabetes
___Scoliosis

Other Health Problems/Surgeries

____
____
____
____
____

Do you currently smoke tobacco of any kind? ☐ Yes ☐ Former Smoker ☐ Never been a smoker
If yes, how often do you smoke? ☐ Current every day smoker ☐ Current sometimes smoker

Current Medications:

☐ No Medications ☐ List provided to staff

Generic/Brand Name	Dosage	Generic/Brand Name	Dosage
1)______________________	_________	3)______________________	________
2)______________________	_________	4)______________________	________

List any known medication allergies: ☐ Check here if no known

____

Race
___American Indian or Alaska Native
___Asian
___Black/African American
___Native Hawaiian or other pacific island
___White
___I choose not to specify

Ethnicity
___Hispanic/Latino
___Not Hispanic/Latino
___I choose not to specify

Preferred Language
___English
___Spanish
___Other_____________
___I choose not to specify

Patient Signature:____ **Date:**____/_____/20____