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

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) _____ (cell) _____
How did you hear about us? _____
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 _____
Symptoms are relieved by: _____
Symptoms are worsened by: _____
Have you ever had same condition? ❑ No ❑ Yes If yes, when? _____
List other practitioners seen for this injury/condition _____
What medical diagnosis, if any, have you received for this condition? _____
Have you ever been under chiropractic care? ❑ No ❑ Yes Acupuncture care? ❑ No ❑ Yes
If yes, please describe _____
How do you feel about acupuncture and Oriental Medicine? _____

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 # _____

Billing Address

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 _____. Are you currently, or trying to become, 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 condition, dosage, and frequency).
_____
_____

Have you ever:	No	Yes	Briefly Explain
Broken bones?	❑	❑	
Been hospitalized?	❑	❑	
Been in an auto accident?	❑	❑	
Had Sprains/Strains?	❑	❑	
Been struck unconscious?	❑	❑	
Had surgery?	❑	❑	

Family History

Family Member	Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	❑ No ❑ Yes
Do your symptoms interfere with daily life?	❑ No ❑ Yes
Does pain wake you up at night?	❑ No ❑ Yes
Are your symptoms worse during certain times of the day?	❑ No ❑ Yes
Do changes in weather affect your symptoms?	❑ No ❑ Yes
Do you wear orthotics?	❑ No ❑ Yes
Do you take vitamin supplements?	❑ No ❑ Yes
What activities aggravate your symptoms?	❑ No ❑ Yes

_____
_____
_____

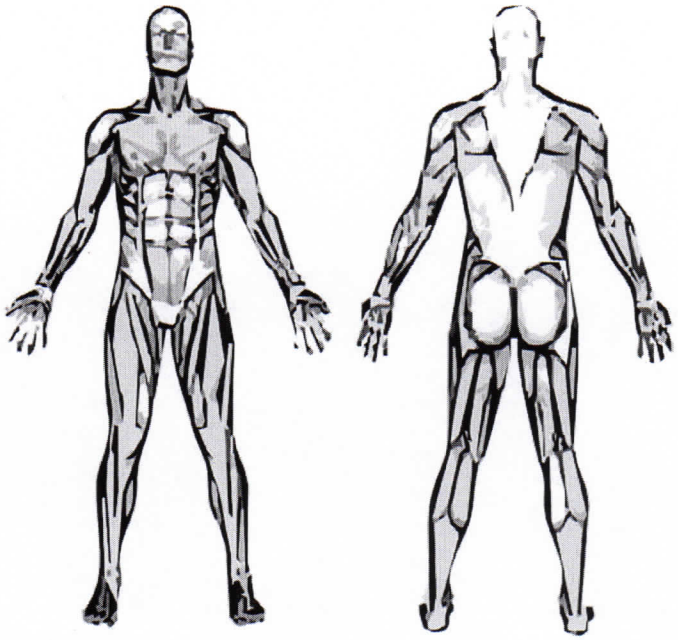
Habits	None	Light	Moderate	Heavy
Alcohol	❑	❑	❑	❑
Coffee	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑
Drugs	❑	❑	❑	❑
Exercise	❑	❑	❑	❑
Sleep	❑	❑	❑	❑
Appetite	❑	❑	❑	❑
Soft Drinks	❑	❑	❑	❑
Water	❑	❑	❑	❑
Salty Foods	❑	❑	❑	❑
Sugary Foods	❑	❑	❑	❑
Artificial Sweeteners	❑	❑	❑	❑

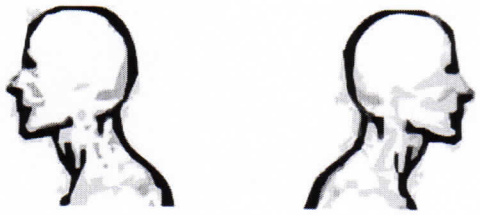
Have you ever suffered from:

- ❑ AIDS/HIV
- ❑ Alcoholism
- ❑ Allergies
- ❑ Anemia
- ❑ Arteriosclerosis
- ❑ Back Pain
- ❑ Birth Trauma
- ❑ Breast lump
- ❑ Bronchitis
- ❑ Bruise Easily
- ❑ Cancer
- ❑ Chest Pain
- ❑ Cramps
- ❑ Diabetes
- ❑ Digestion Problems
- ❑ Drug Addictions
- ❑ Emphysema
- ❑ Eye Pain/Difficulties
- ❑ Fibromyalgia
- ❑ Heart Disease
- ❑ Hepatitis A/B/C
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ Hot Flashes
- ❑ Joint Replacements
- ❑ Loss of balance
- ❑ Loss of memory
- ❑ Loss of smell
- ❑ Loss of taste
- ❑ Lumps In Breast
- ❑ Lyme's Disease
- ❑ Lymph Nodes removed
- ❑ Multiple Sclerosis
- ❑ Neck Pain or Stiffness
- ❑ Pacemaker
- ❑ Polio
- ❑ Poor Posture
- ❑ Prostate Trouble
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Sciatica
- ❑ Seasonal Allergies
- ❑ Seizures
- ❑ Sinus Infection
- ❑ Sleep Disorders
- ❑ Spinal Curvatures
- ❑ Stroke
- ❑ Swelling of ankles
- ❑ Thyroid Condition
- ❑ Tuberculosis
- ❑ Venereal Disease
- ❑ Other:

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache
B=Burning
N=Numbness
O=Other
P=Pins & Needles
S=Stabbing





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Questionnaire

In order to keep current with the healthcare industry there are some bits of information we need to keep your file up to date. Thank you for taking time to give us this information.

Name: _____ Preferred Language: _____

Height: _____ Weight: _____ Blood Pressure: _____

Ethnicity: Hispanic Non-Hispanic Rather not say

Smoking Status: Never Smoked Current Smoker Former Smoker
Years smoked?_____ Years quit?_____

Do you have any drug allergies? Yes No

If so, which drugs?

_____ Type of reaction?_____
_____ _____
_____ _____
_____ _____
_____ _____

What drugs are you currently taking?

_____ Frequency per day?_____
_____ _____
_____ _____
_____ _____
_____ _____

Signature: _____ Date: _____