# New Patient Health History Form

**In order to provide you the 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: ______

Age: ______ Birth Date: ______ Number of children: ______ Marital Status: ______

Occupation: ______ Employer: ______

Spouse's Name: ______ Spouse's Occupation: ______

Spouse's Employer: ______ Spouse's Health Status: ______

Referred by: ______

**Emergency Contact:** ______ **Phone:** ______

## Address/Phone

Address: ______ City: ______ State: ______ Zip: ______

Cell: ______ Home: ______ Work: ______ Ext: ______

Email:* ______

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

## Current Complaints

Nature of Injury : ☐ Automobile ☐ Work ☐ Other

Please Describe: ______

Date Symptoms Appeared: ______

Have you ever had same condition: ☐ Yes ☐ No If yes, when? ______

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 Company: ______

Insurance Company Member/Policy number: ______

## 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 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 a chance that you are pregnant? ☐ Yes ☐ No

Have you had X-rays taken? ☐ Yes ☐ No 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? | ☐ | ☐ | |
| Been hospitalized? | ☐ | ☐ | |
| Been in an auto accident? | ☐ | ☐ | |
| Had sprains/strains? | ☐ | ☐ | |
| Been struck unconscious? | ☐ | ☐ | |
| Had surgery? | ☐ | ☐ | |

## Family History

Family Members: Past and present health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

| Have you ever: | No | Yes |
| --- | --- | --- |
| Do you experience pain every day? | ☐ | ☐ |
| Do your symptoms interfere with daily life? | ☐ | ☐ |
| Does your 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?

| 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:**

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ 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
- ☐ Poor Posture
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Neck Pain or Stiffness
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of breath
- ☐ Sinus Infection
- ☐ Sleep problems or Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Other: ________________________

Doctor's Notes:

______________________________________________________

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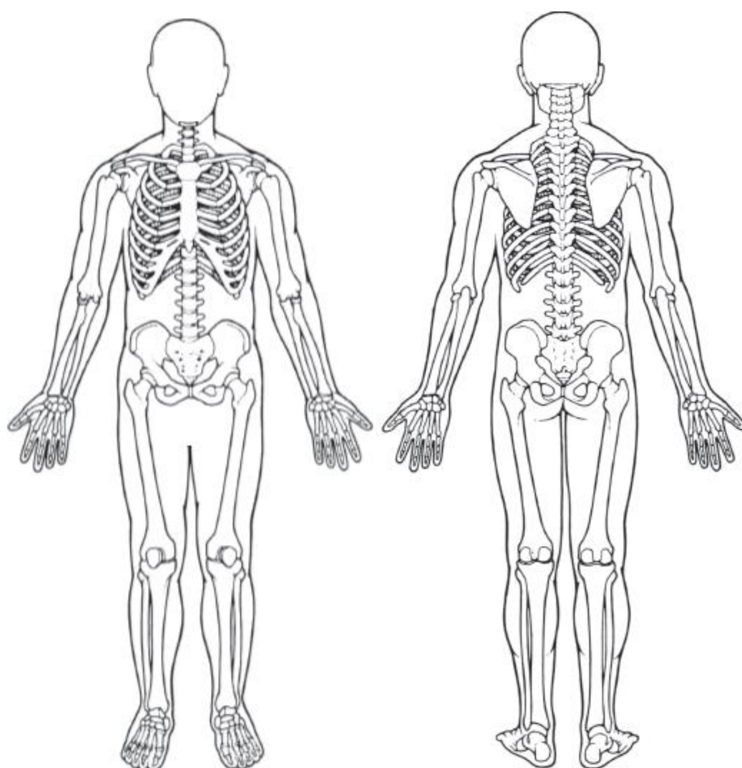

Please use the following letters to indicate TYPE & LOCATION of the symptoms you are currently experiencing.

**A** = Ache **B** = Burning

**N** = Numbness **P** = Pins & Needles

**S** = Stabbing **O** = Other