• Mobility Chiro •

New Patient Health History Form

In order to provide you with the best possible care, please complete this form, and have it with you at your first appointment. All fields are required, and all information is strictly confidential.

Patient Data

Name _____ Date of Birth _____ Age _____ ☐ M ☐ F

Address _____ City _____ State _____ ZIP _____

Telephone (Home) _____ (Work) _____ (Cell) _____

Cell Provider ☐ AT&T ☐ Sprint ☐ Verizon ☐ Other _____ Referred By _____

Email (NOT shared) _____ SS No. _____ No. of Children _____

Occupation _____ Employer _____ Marital Status _____

Employer's Address _____ City _____ State _____ ZIP _____

Spouse's Name _____ Spouse's Occupation _____ Spouse's Employer _____

Emergency Contact _____ Relationship _____ Telephone _____

Medical History

Have you been treated for any conditions in the past year? ☐ No ☐ Yes

If yes, please describe _____

Date of your last physical exam _____ Is there a chance that you are pregnant? ☐ No ☐ Yes

Have you had X-rays taken? ☐ No ☐ Yes When?_____ Where? _____

What medications are you taking, and for what conditions? Please list the dosages, etc.

_____

_____

_____

What vitamins, minerals or herbs are you taking, and for what conditions? Please list the dosages, etc.

_____

_____

_____

Have You Ever	No	Yes	Description
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, arthritis, etc.)

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

Current Complaints

Nature of injury ☐ Automobile Accident ☐ Work Related ☐ Other

Please describe _____

_____

Date of injury _____ Date symptoms appeared _____

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

List other practitioners seen for this condition _____

Have you ever been under chiropractic care? ☐ No ☐ Yes

If yes, please describe _____

Do you wear orthotics? ☐ No ☐ Yes

Symptoms	No	Yes
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?	☐	☐
Have you had any sudden weight loss?	☐	☐
What activities aggravate your symptoms?		

Signature

Patient Signature _____ Date _____

Parent Signature (if a minor) _____ Date _____

Have You Suffered From	No	Yes
Alcoholism	☐	☐
Allergies	☐	☐
Anemia	☐	☐
Arteriosclerosis	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Back Pain	☐	☐
Breast Lumps	☐	☐
Bronchitis	☐	☐
Bruise Easily	☐	☐
Cancer	☐	☐
Chest Pains	☐	☐
Cold Hands/Feet	☐	☐
Constipation	☐	☐
Cramps	☐	☐
Depression	☐	☐
Diabetes	☐	☐
Digestion Problems	☐	☐
Dizziness/Loss of Balance	☐	☐
Ear Pain/Ringing	☐	☐
Eye Pain/Difficulties	☐	☐
Fatigue	☐	☐
Frequent Urination	☐	☐
Headaches	☐	☐
Hemorrhoids	☐	☐
High Blood Pressure	☐	☐
Hot Flashes	☐	☐
Irregular Heart Beat	☐	☐
Kidney Infection/Stones	☐	☐
Loss of Memory	☐	☐
Loss of Smell or Taste	☐	☐
Menstrual Problems	☐	☐
Neck Pain/Stiffness	☐	☐
Nervousness	☐	☐
Nosebleeds	☐	☐
Pacemaker	☐	☐
Polio	☐	☐
Poor Posture	☐	☐
Prostate Trouble	☐	☐
Sciatica	☐	☐
Shortness of Breath	☐	☐
Sleep Difficulties/Insomnia	☐	☐
Spinal Curvatures	☐	☐
Stroke	☐	☐
Swollen Ankles	☐	☐
Swollen Joints	☐	☐
Thyroid Condition	☐	☐
Tuberculosis	☐	☐
Ulcers	☐	☐
Varicose Veins	☐	☐
Venereal Disease	☐	☐
Other (describe)		

Please Use the Following Key to Indicate TYPE and LOCATION of Current Symptoms

A=Ache	**O=Other**
B=Burn	**P=Pins**
N=Numb	**S=Stab**