## **NewPatientHealthHistoryForm**

In order to provide you the best 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	E	Email*	
* Your email v	vill NOT be shared with	any 3d parties, ar	nd is used fo	or occasional of	ffice announce	ements and promotions.
Mailing address						
Address		City			State	Zip
Telephone (Work)	1	home)		Re	ferred By	
Age Birth Date	Sc	ocial Security #		Numk	per of Children	
Occupation		Employe	r			
Marital Status	Spouse's Name			Spouse's O	ccupation	
Spouse's Employer		Spouse'	s Health Sta	atus		
Emergency Contact		Phone				
<b>Current Complaints</b>						
Nature of Injury: Automo	obile*	Other				
Please describe:						
riedse describe.						
Date if Injury	Date symptoms ap	peared				
Have you ever had same co	$\square$ ondition? $\bigcirc$ No $\bigcirc$	Yes If yes, wh	en?			
List of other practitioners see	0	on				
Have you ever been under	chiropractic care?	No O Yes				
If yes, please describe		() 1.63				
Insurance Information	n .					
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Name of party responsible f				Ph	one	
Do you have health insuran		Name of compan	У			
* If an auto accident, pleas	e provide:	0-1	- t t D			
Insurance Company Name	Clains #	Col	ntact Perso	on		
Phone:	Claim #					
Signatures						
Name of the insured _	I understand and agree	that health/accides	t incurance	nolicios aro an an	rangoment hat	ween an insurance carrier
	and myself. I understand					
	responsibility for timely professional services ren	payment. I underst	and that if I	suspend or term	inate my care/t	
Patient's signature	professional services fell	dered to file will be	mmediatei		e. 	
Spouse's or guardian's	s signature			Date		

Medical History							
Have you been treated for any conditions in the last ye	ear? O No	O Yes	S				
If yes, please describe							
Date of last physical exam Is the	Date of last physical exam Is there a chance that you are pregnant? O No O Yes						
Have you had X-rays taken? O No O Yes If Yes	Have you had X-rays taken? O No O Yes If Yes, where?						
What medications are you taking and for what conditi	ions (Please	list dosag	ge and amour	ıts, etc)l			
What vitamins, minerals, or herbs do you currently take	2 (Please lis	t for what	t conditions d	osage and fr	requency)		
Title vital in is, militarais, or horse do you containly take	7: (1 10 d30 113	1101 111101	CONTAINIONS, O	<u>03490, 4114 11</u>	oquericy).		
Have you ever:	No Yes	Briefly	Explain				
Broken bones?	00						
Been hospitalized?	00000C						
Been in an auto accident?	0000						
Had Sprains/Strains? Been struck unconscious?	XX						
Had surgery?	$ \mathcal{C}\mathcal{C} $						
	0 0	<u> </u>					
Race and Ethnicity							
Race and Emmeny							
Race □ American Indian □ Alaskan Native □ Asian □ Black or African American □ Native Hawaiian □ Other Pacific Islander							
Ethnicity □ Hispanic or Latino □ Not Hispanic or Latino							
Preferred Language □ English □ Spanish □ Other							
Do you experience pain every day?					0	No OYes	
Do your symptoms interfere with daily life?					_	No OYes	
					No OYes		
					No OYes		
Do changes in weather affect your symptoms?  No OYes						Ξ	
Do you wear orthotics?  Do you take vitamin supplements?  O No O Yes  O No O Yes							
What activities aggravate your symptoms?							
Habits			None	Light	Moderate	Heavy	
Alcohol Coffee			Q	Q	Q	Q	
Tobacco			$\otimes$	$\otimes$	8	$\mid  \  \  \  \  \  \  \  \  \  \  \  \  \$	
Drugs			X	X	l X	$\mid  \  \  \  \  \  \  \  \  \  \  \  \  \$	
Exercise			Ŏ	Ŏ	ĮŽ	Q	
Sleep Appetite			$\times$	$\bowtie$	1 8	$\mid \hspace{0.1cm} \hspace{0.1cm}$	
Soft Drinks			$\forall$	$\forall$	l X	$\mid  \  \  \  \  \  \  \  \  \  \  \  \  \$	
Water Salty Foods Sugary			Q	Q	l Ø	Q	
Salty Foods Sugary Foods Artificial						$\times$	
Sweeteners 8 8 8						ŏ	

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Allergies   Anemia   Aretriosclerais   AFAche   O-Cother		Please use the following letters to indicate TYPE and
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