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 ____________

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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	❑	❑	❑	❑

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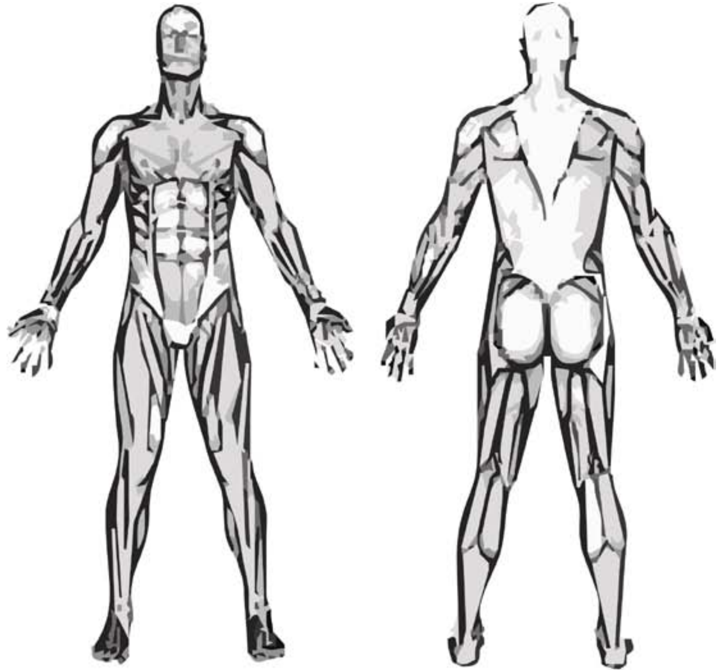
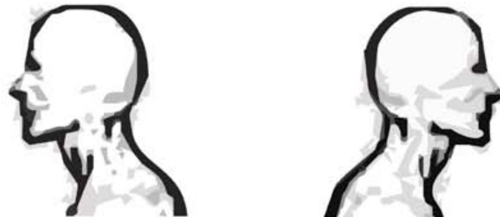
Have you ever suffered from:	
❑ AIDS/HIV ❑ Alcoholism ❑ Allergies ❑ Anemia ❑ Arteriosclerosis ❑ Back Pain ❑ Birth Trauma ❑ Breast lump ❑ Bronchitis ❑ Bruise Easily ❑ Cancer ❑ Chest Pain ❑ Cramps ❑ Diabetes ❑ Digestion Problems ❑ Drug Addictions ❑ Emphysema ❑ Eye Pain/Difficulties ❑ Fibromyalgia ❑ Heart 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 **O**=Other **B**=Burning **P**=Pins & Needles **N**=Numbness **S**=Stabbing  

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Exercise & Energy

How is your energy Level? _________________ What time of day is your energy highest?___________ Lowest?__________
Do you fatigue easily? ❑ No ❑ Yes What kind of exercise do you do?_____________________ How often?_____________

Emotions & Sleep

How do you feel emotionally?____
Do you have (Check all that apply): ❑ Panic Attacks ❑ Depression ❑ Anxiety ❑ Bad Temper ❑ Nervousness
❑ Fear Attacks ❑ Poor Memory ❑ Difficult Concentration
Are you in a relationship? ❑ No ❑ Yes How do you feel about your relationship?______________________________
How do you hold stress?____
How do you relax?____
How do you feel about your work?____
How long do you normally sleep?_____________ hours per night
I have difficulties with (Check all that apply): ❑ Falling asleep ❑ Staying asleep ❑ Dream-disturbed sleep
❑ Waking up at about __________ am/pm and not being able to go back to sleep

Urinary

Urination: How Often? _______ times per day Color: ❑ Pale Yellow ❑ Dark Yellow/Orange
I have or had (check all that apply): ❑ Trouble Starting Stream ❑ Frequent Urination ❑ Incontinence ❑ Pain
❑ Burning ❑ Dribbling when Sneezing ❑ Blood in Urine ❑ Kidney Stones ❑ Urinary Tract Infections
❑ Other____

Gastrointestinal

I have (check all that apply): ❑ Belching ❑ Nausea ❑ Vomiting ❑ Vomiting of Blood ❑ Ulcers
❑ Bloating ❑ Acid Regurgitation ❑ Heartburn ❑ Hernia ❑ Indigestion ❑ Severe Stomach Pain
❑ Bowel Movements: __________time(s)/day ____________ days/week ❑ Irregular ❑ Constipation ❑ Diarrhea
❑ Gas ❑ Burning Sensation ❑ Hemorrhoids ❑ Undigested Food in Stool ❑ Loose Stool ❑ Hard Stool
❑ Blood in Stool ❑ Itchiness ❑ Painful Bowel Movements

Muscles, Joints & Bones

Do you have pain or tightness? ❑ No ❑ Yes Where: ____
The Pain is (check all that apply) ❑ Sharp ❑ Dull ❑ Aching ❑ Numb ❑ Superficial Pain ❑ Deep Pain
❑ Burning ❑ Tingling ❑ Shooting ❑ Pain worse/better with heat ❑ Pain worse/better with cold ❑ Pain worse/better with pressure ❑ Pain worse in the am/pm
I have (check all that apply) ❑ Swollen Joints ❑ Arthritis/Joint Pain ❑ Tendonitis ❑ Bone Pain ❑ Muscle Cramping ❑ Muscle Pain ❑ Repetitive Strain Injury ❑ Fractured Bone(s) Where:____________________________
❑ Other_______________________________________

Eyes, Ears, Nose, Throat & Head

Do you smoke? ❑ No ❑ Yes ______________per day, for _______________years
I have (Check all that apply): ❑ Frequent Colds ❑ Chronic Runny Nose ❑ Frequent Sore Throat ❑ Chronic Cough ❑ Coughing Blood ❑ Cough up Mucous ❑ Pain Inhaling ❑ Shortness of Breath on Exertion/At Rest
❑ Asthma ❑ Nose Bleeds ❑ Painful/Red Eyes ❑ Poor Vision ❑ See Spots/Floaters ❑ Dizziness ❑ Cold Sores
❑ Bleeding Gums ❑ Dry Mouth ❑ Ear Pain ❑ Ringing in Ears ❑ Clogged/Popping in Ears ❑ Frequent Headaches/Migraines, Describe:____

Cardiovascular

I have (check all that apply): ❑ Chest Pain ❑ Palpitation ❑ Varicose Veins ❑ Phlebitis ❑ Irregular Heartbeat ❑ Cold Hands/Feet ❑ Poor Circulation ❑ Other____

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Skin & Hair

I have (check all that apply): ❑ Dry Skin ❑ Skin Rashes ❑ Itching ❑ Acne ❑ Eczema ❑ HIves ❑ Hair Loss
❑ Premature Graying ❑ Other____

Women

At what age did you start menstruating? ______________
Number of days between cycles: _______________ Number of days in flow: ______________ What color: _______________
I have or had (check all that apply):❑ Irregular Menstruation ❑ Heavy Flow ❑ Light Flow ❑ No Flow ❑ Clots
❑ Vaginal Itching/Burning ❑ Spotting ❑ Discomfort/Pain before period ❑ Discomfort/Pain during Period
Other:____ Any vaginal discharge? ❑ No ❑ Yes Color:______________

Men

I have or had (check all that apply):❑ Prostatitis ❑ Impotence ❑ Penis Blood/Mucous discharge
Other:____

Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on ___________________________, by the licensed doctors of chiropractic, medical doctors, licensed physical therapists, and/or licensed massage therapists who may be employed by or engaged in practice at Twin Oaks Chiropractic & Acupuncture.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation / adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic & acupuncture health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, infection, bruising, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

Date of last menstrual period ________________.

____
Patient's Name (Print)

____ ____________________
Guardian's Name (If Applicable) Date

____ ____________________
Patient's or Guardian's Signature Date

____ ____________________
Relationship or Authority if not signed Date

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