

# New Patient Health History Form

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  Email\*

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

## Mailing address

Address  City  State  Zip

Telephone (Work)  (home)  Referred By

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

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

List of other practitioners seen for this injury/condition

Have you ever been under chiropractic care?  No  Yes

If yes, please describe

## 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 #

## 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'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

Is there a chance that you are 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 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 - 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

Alcohol

Coffee

Tobacco

Drugs

Exercise

Sleep

Appetite

Soft Drinks

Water

Salty Foods

Sugary Foods

Artificial Sweeteners

None

Light

Moderate

Heavy

**Have you ever suffered from:**

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

