New Patient Health History Form

Patient Data

Name:________________________ Date:__________ **E-mail**____________________
Initial here to receive online health newsletter ______

Address:________________________ City:____________ State:________ Zip:________

Home Phone:______________ Cell Phone:______________ Work Phone:______________

Date of Birth:___/___/______ Social Security Number:______-______-______ Referred by:____________

Gender: Male / Female Number of Children:______ Single____ Married____

Height: _____ft _____inches Weight:__________

Occupation:________________________ Employer:________________________

Emergency Contact:________________________ Phone:________________________

Current Complaints

Nature of Injury: Auto_____ Work_____ Other_____

Please describe:____

____

Date of Onset:____/____/________ Date Symptoms Appeared:____/____/________

On a scale of 1-10, 10 being most severe, rate your pain today:__________

Is this a preexisting condition? Yes_____ No______ If yes, when? ____________________

List other practioners seen for this condition:________________________________

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_____

If yes, company name:________________________

If auto accident related or work related injury (worker compensation case) provide:

Insurance company name:____________________ Claim number:____________________

Contact person:________________________ Phone:________________________

Medical History

Have you been treated for any conditions in the last year? Yes______ No______

If yes, please describe:____

____

Date of last physical exam:_____/_____/________ Are/could you be pregnant? Yes______ No______

Have you had X-rays taken? Yes______ No______ If yes, where?______________________

Please list any allergies:____

____

List any and all medications you are currently taking and what condition they are for (include dosage, amounts etc.)____

____

____

What vitamins, minerals or herbs are you currently taking? (Please list for what condition, dosage and frequency)

____

____

____

Have You Ever:	Yes	No	Briefly Explain
Broken Bones	____	____	____________________
Been Hospitalized	____	____	____________________
Been in an auto accident	____	____	____________________
Had sprains/strains	____	____	____________________
Been struck unconscious	____	____	____________________
Had surgery	____	____	____________________

Family History

Maternal Side (examples: heart disease, diabetes, cancer, arthritis)

Past and/or present health conditions:____

____

Paternal Side

Past and/or present health conditions:____

Siblings
Past and/or present health conditions:____

____

Activities

Exercise: ____None ____Moderate ____Daily ____Heavy

Work Activity: ____Sitting ____Standing ____Light Labor ____Heavy Labor

Habits:

____Smoking packs/day__________

____Alcohol drinks/week__________

____Coffee/Caffeine cups/day__________

____High Stress Level reason__________

Do you experience pain every day? Yes____ No____

Do your symptoms interfere with daily life? Yes____ No____

Does pain wake you up at night? Yes____ No____

Are your symptoms worse during a certain time of the day? Yes____ No____

If yes, describe:____

Do weather changes affect your symptoms? Yes____ No____

Do you wear orthotics? Yes____ No____

What activities aggravate your symptoms?____

____

I authorize the staff to perform any necessary services needed during diagnosis and treatment. Furthermore, risks involving treatment will be explained to me upon request. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to this clinic all insurance benefits. if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submission.

______________________________ ____________________ ____________

Patient or Responsible Party Signature **Relationship to Patient** **Date**

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/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/insomnia
- [ ] Spinal Curvatures
- [ ] Stroke
- [ ] Swelling of ankles
- [ ] Swollen Joints
- [ ] Thyroid Condition
- [ ] Tuberculosis
- [ ] Ulcers
- [ ] Varicose Veins
- [ ] Venereal Disease
- [ ] Other:

Current Complaints (Continued)

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

A=Ache
B=Burning
N=Numbness
O=Other
P=Pins & Needles
S=Stabbing