

# 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 general 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 other practioners 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 # \_\_\_\_\_

## 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 \_\_\_\_\_

## 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 condition, dosage, and frequency).

\_\_\_\_\_

## Have you ever:

	No	Yes	Briefly Explain
Broken bones?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been in an auto accident?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had Sprains/Strains?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been struck unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____

## Family History

Family Member	Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

## Habits:

	None	Light	Moderate	Heavy		Yes	No
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you experience pain every day?	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do your symptoms interfere with daily life?	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does pain wake you up at night?	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are your symptoms worse during certain times of the day?	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do changes in weather affect your symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear orthotics?	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you take vitamin supplements?	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What activities aggravate your symptoms?		
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Sugary Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		

**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

