

# 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) \_\_\_\_\_ 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.)

Do you experience pain every day?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do your symptoms interfere with daily life?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Does pain wake you up at night?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are your symptoms worse during certain times of the day?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do changes in weather affect your symptoms?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you wear orthotics?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you take vitamin supplements?	<input type="checkbox"/> No <input type="checkbox"/> Yes
What activities aggravate your symptoms? _____ _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes

Habits	None	Light	Moderate	Heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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:

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

