



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 ADDRESS		

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

Whom may we thank for referring you to our office today?	Would you like to Opt In for Text Message Appointment Reminders? <input type="radio"/> Yes <input type="radio"/> No
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MAILING ADDRESS

ADDRESS		CITY	
STATE	ZIP CODE	HOME PHONE	CELL PHONE
AGE	BIRTH DATE	SOCIAL SECURITY #	OCCUPATION
MARITAL STATUS	SPOUSE'S NAME		SPOUSE'S OCCUPATION
NAMES & AGES OF MINOR CHILDREN			
IN AN EMERGENCY CONTACT:			PHONE

CURRENT COMPLAINTS

NATURE OF INJURY/ONSET: <input type="radio"/> Automobile* <input type="radio"/> Work <input type="radio"/> Other	DATE OF INJURY/ONSET	
PLEASE DESCRIBE YOUR INJURY/COMPLAINT:		
WHEN DID YOUR SYMPTOMS FIRST APPEAR?	HAVE YOU EVER HAD THE SAME CONDITION? <input type="radio"/> Yes <input type="radio"/> No	IF YES, WHEN?
PLEASE LIST OTHER PRACTITIONERS SEEN FOR THIS INJURY/CONDITION		
HAVE YOU EVER BEEN UNDER CHIROPRACTIC CARE? <input type="radio"/> Yes <input type="radio"/> No	IF YES, PLEASE DESCRIBE:	

INSURANCE INFORMATION

NAME OF PARTY RESPONSIBLE FOR PAYMENT		PHONE	
DO YOU HAVE HEALTH INSURANCE? <input type="radio"/> Yes <input type="radio"/> No	NAME OF HEALTH INSURANCE COMPANY		
*IF AN AUTO ACCIDENT, PLEASE PROVIDE:	INSURANCE COMPANY NAME	POLICY NUMBER	CLAIM NUMBER
CONTACT PERSON		CONTACT PHONE NUMBER	

SIGNATURES

NAME OF THE INSURED _____

I understand and agree that health/accident insurance policies are an arrangement between me and my insurance company. 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, any fees for professional services rendered to me will be immediately due and payable. Further, by my signature, I hereby give the doctor consent to treat my condition following a report of findings of my initial exam.

PATIENT'S SIGNATURE _____ DATE _____

SPOUSE'S OR GUARDIAN'S SIGNATURE _____ DATE _____

MEDICAL HISTORY

Have you been treated for any conditions in the last year? Yes No | IF YES, PLEASE DESCRIBE: _____

Is there any chance that you are pregnant? Yes No

What medications are you taking and for what conditions?

What vitamins, minerals or herbs do you currently take?

PLEASE ANSWER

BRIEFLY DESCRIBE/EXPLAIN

Have you broken any bones?	<input type="radio"/> Yes	<input type="radio"/> No	
Have you been hospitalized?	<input type="radio"/> Yes	<input type="radio"/> No	
Have you been in an auto accident?	<input type="radio"/> Yes	<input type="radio"/> No	
Have you had any Sprains/Strains?	<input type="radio"/> Yes	<input type="radio"/> No	
Have you been struck unconscious?	<input type="radio"/> Yes	<input type="radio"/> No	
Have you had surgery?	<input type="radio"/> Yes	<input type="radio"/> No	
Do you experience pain every day?	<input type="radio"/> Yes	<input type="radio"/> No	
Do your symptoms interfere with daily life?	<input type="radio"/> Yes	<input type="radio"/> No	
Does pain wake you up at night?	<input type="radio"/> Yes	<input type="radio"/> No	
Are your symptoms worse during certain times of the day? If so, when?	<input type="radio"/> Yes	<input type="radio"/> No	

What activities aggravate your symptoms?

HABITS	NONE	LIGHT	MODERATE	HEAVY		NONE	LIGHT	MODERATE	HEAVY
Alcohol					Appetite				
Coffee					Soft Drinks				
Tobacco					Water				
Recreational Drugs					Salty Foods				
Exercise					Stress				
Sleep					Sugary Foods				

IN THE PAST YEAR, HAVE YOU SUFFERED FROM: *(Please check all that apply)*

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Constipation | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cramps | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Sinus Infection |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Depression | <input type="checkbox"/> Irregular Cycle | <input type="checkbox"/> Sleep problems or Insomnia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Digestion Problems | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Spinal Curvatures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Swollen Joints |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Excessive Menstruation | <input type="checkbox"/> Neck Pain or Stiffness | <input type="checkbox"/> Thyroid Condition |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headache | <input type="checkbox"/> Poor Posture | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Chest Pain/Conditions | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Prostate Trouble | |
| <input type="checkbox"/> Cold Extremities | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sciatica | |
| <input type="checkbox"/> Other: <i>(Please describe)</i> _____ | | | |

Using Key below, indicate and label location of your discomfort in the body outlines and rate them from 1 to 10 (1 being mild and 10 extreme).

- A** – Ache **B** – Burning **D** – Dull Pain **N** – Numbness **P** – Spasm **S** – Stiff **T** – Tingling **X** – Sharp
O – Other *(Please describe)*

