

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, reminders, 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 practitioners seen for this injury/condition _____

Have you ever been under chiropractic care? No Yes

If yes, please describe _____

Guidelines

We will be required to provide you with a clinical summary after each visit.

Would you like to receive these summaries by email? No Yes

We are required to provide you with electronic reminders if you choose.

Would you like to receive these reminders? No Yes

Would you like to receive our weekly health updates by email? No Yes

Have you ever had an x-ray, MRI, or CT scan taken of your lower back? No Yes

Do you smoke? Yes (everyday) Yes (some days) No (formerly) No (never)

Are you allergic to any medicine? No Yes If Yes, please list: _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Prefer not to answer

Race: American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White Prefer not to answer

For Office Use

Height: _____ Weight: _____ BP: _____ Pulse: _____ Date: _____

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 Agreement

Name of the insured _____

This office will bill all applicable insurances including 1st party primary and secondary and any 3rd part at fault insurance through a lien.

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that this Chiropractic Office will prepare the usual reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. Should an amount on this account become delinquent, I agree to pay all interest, court costs, attorney fees, and reasonable collection costs with or without suit. Accounts on which no payment is made in a 30 day period are subject to a 1.5% per month or 18% annum interest charge.

If my insurance deems my care medically unnecessary I will be held liable for all services rendered. In addition if we in good faith bill your insurance and you are not covered, unaware of a deductible, or otherwise have no coverage, you will be held liable financially

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"/>

- 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 Location of the symptoms you currently are Experiencing.

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

