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 _____

Mailing address

Address _____ City _____ State _____ Zip _____

Telephone (Home) _____ (work) _____ 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

***Would you like to receive appt. reminders by text message? ❑ No ❑ Yes (cell#)**_____

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

Do you smoke? ❑ Yes(everyday) ❑ Yes (some days) ❑ No(formerly) ❑ No(never)
Are you allergic to any medicine? ❑ No ❑ Yes If Yes, please list:_____
_____

For Office Use

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

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?	❑	❑	
Been hospitalized?	❑	❑	
Been in an auto accident?	❑	❑	
Had Sprains/Strains?	❑	❑	
Been struck unconscious?	❑	❑	
Had surgery?	❑	❑	

Family History

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

Do you experience pain every day?	❑ No	❑ Yes
Do your symptoms interfere with daily life?	❑ No	❑ Yes
Does pain wake you up at night?	❑ No	❑ Yes
Are your symptoms worse during certain times of the day?	❑ No	❑ Yes
Do changes in weather affect your symptoms?	❑ No	❑ Yes
Do you wear orthotics?	❑ No	❑ Yes
Do you take vitamin supplements?	❑ No	❑ Yes
What activities aggravate your symptoms?	❑ No	❑ Yes

Habits	None	Light	Moderate	Heavy
Alcohol	❑	❑	❑	❑
Coffee	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑

Drugs	❑	❑	❑	❑
Exercise	❑	❑	❑	❑
Sleep	❑	❑	❑	❑
Appetite	❑	❑	❑	❑
Soft Drinks	❑	❑	❑	❑
Water	❑	❑	❑	❑
Salty Foods	❑	❑	❑	❑
Sugary Foods	❑	❑	❑	❑

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
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**